Vol. XXVIII. DECEMBER, 1932 No. 12

The Distribution of Nursing Services

Introduced by JEAN E. BROWNE, Director of Junior Red Cross for Canada and Nurse Member of the Joint Study Committee, Survey of Nursing Education in Canada.

Although rumblings of dissatisfaction in regard to the distribution of nursing services have been steadily growing more insistent in Canada, the revelations of the Survey came as a distinct shock even to those who were keeping their ears to the ground. They revealed the fact that approximately 60 per cent of the people in Canada needing nursing care do not have the services of a trained nurse; yet 40 per cent of private duty nurses are continuously unemployed.

What is the explanation? A density map in the Survey Report shows that two-thirds of the nurses are concentrated in 25 cities which make up one-third of the population. People in rural areas are obviously not well served. There is also evidence that only three out of eight patients of moderate means who need the graduate nurse are able to engage her.

Unthinking people have been prone to blame this unfortunate state of affairs solely on the nurse. They have said she would not face the hardships of rural nursing, that she preferred to live more at ease in cities. Those who know rural conditions in Canada realise that it is, for the most part, impossible for a free-lance nurse to settle in a rural community and earn a living. Again, the unthinking have assumed that all would be well with the patients of moderate means if the nurse would reduce her fees. The Survey has made a very detailed report on the income and savings of private duty nurses. The median annual income for Canada was $1,022. This amount includes the equivalent in money that otherwise would have been paid by the nurse for lodging, board and laundry if she were not on nursing duty. The actual cash received by the nurse is, therefore, several hundred dollars less than the amount stated. It is manifest that on this salary it is impossible to make any provision for the future. Indeed, to quote from the Report: "Many private duty nurses see economic disaster staring them in the face and not a few are deeply worried by the spectre of a poverty-stricken old age." In these circumstances, the reducing of fees is obviously not the solution of a general and distressing social problem.

An informed public sentmient is beginning to take shape, looking towards some form of co-operative effort as the way out. The Survey crystallizes this sentiment in a definite scheme of socialisation of nursing services which would largely bridge the gap between the needy patient, unable to pay graduate nursing fees, and the unemployed graduate nurse unable to market her services in 60 per cent of the cases of illness.

Some good people are almost stampeded by this term "socialisation." They fear it is synonymous with communism, and sniff a men-

(Papers read at a General Session, Canadian Nurses Association General Meeting, June 24, 1932.)

ace associated with it. Socialisation of health services is not new in principle in Canada. We have examples of it in every public health department, and in every province where the Workmen's Compensation Act is in operation. The extension of this principle to the distribution of nursing services among all the people of moderate means in Canada who need such services, is the original contribution of the Survey. Apparently it is much needed, for according to evidence reported to the Survey by social workers, about 50 per cent of the families in Canada live on an annual income of approximately $2,000 or less. After meeting the costs of shelter, food and clothing it is obvious that such families have practically nothing left for hospital, doctors', nurses' or dental charges.

The whole plan of socialisation of nursing services dealt with in the Survey Report depends on a scheme of Compulsory Health Insurance under defined income limits for three classes:

(a) Wage-earners

(b) Salaried people

(c) A class enjoying certain financial independence in the sense that they belong to neither of the above classes, such as small merchants, retailers, farmers, etc.

The plan could be financed by contributions from the following sources:

(a) The insured

(b) The employer (in the case of salaried people and wage-earners)

(c) The Provincial Government

(d) The Federal Government (if possible)

This scheme is an extension of the principle of Social Insurance which was developed first in Germany nearly fifty years ago. At this stage it was limited to Industrial Accident Insurance, the forerunner of our Canadian Workmen's Compensation Acts, and to what was called Compulsory State Sickness Insurance. Since then social schemes of Old Age Pensions, Widows' and Orphans' Pensions, Mothers' Allowances and Unemployment Insurance have been worked out in various parts of the world.

The desirability of tracing sickness first of all, preventing it whenever possible, and treating it when prevention has been unsuccessful, are fundamental problems. That nursing has a large part to play in both the preventive and curative aspects cannot seriously be doubted. But nursing is only part of the scheme as indicated in the Weir Report. The Report states that complete health service should be provided.

(1) Hospitalisation, Medical, Nursing and Dental.

(2) All members of the family should be included.

(3) Home as well as hospital service: full-time nursing, hourly nursing, visiting housekeepers, etc.

(4) Clinics: pre-natal and post-natal and public health teaching.

The question which I am sure presents itself to this practical audience in connection with such a scheme is: how to prevent the abuse of this system through malingering or from a desire on the part of some of the insured to get "their money's worth." The Survey Report recommends charging a nominal fee, on a percentage basis of the cost of nursing care.

But the social worker may object —"If your family had no money, how could it pay?" Obviously it could not pay any more than, under present conditions, it could pay for health services or for clothing, groceries, etc. To provide against

unemployment contingencies, the Survey Report recommends that it might be advisable to insert a three months' or so "carrying period" in the Insurance Act. Furthermore, state health insurance is designed particularly to meet the health situation as it affects people of moderate means, or about the middle 50 per cent of the population. A family of five, belonging to this class, would ordinarily pay, under present conditions, nearly fifty dollars annually in dental bills alone, and according to evidence submitted by a number of doctors to the Survey, this amount paid towards a state health insurance scheme should obtain a complete service, including medical, dental, nursing and hospital care. The Survey does not vouch for this statement, as it repeatedly states that the working out of these details must be left to actuarial investigation.

To many nurses, compulsory health insurance in Canada may have all the novelty of a completely new idea. Nevertheless, investigations have been taking place in British Columbia, Alberta, Manitoba and Quebec. In February, 1929, a Royal Commission was appointed in British Columbia to enquire into the matter. The Commission presented a Progress Report on February 11, 1930, to the effect that "there is justification and a general demand for the introduction in British Columbia of an economically sound and equitable public health insurance plan" and the Alberta report on an "Inquiry into Systems of State Medicine" was given in 1929. In Manitoba Dr. E. S. Moorehead, Chairman of the Welfare Supervision Board of the Provincial Department of Health and Public Welfare, made an investigation "On the Feasibility of the Introduction of a Contributory Health Insurance Scheme to the Province of Manitoba" and in Quebec a Social Insurance Commission has been investigating Social Insurance for some months. The Federal Department of Labour has also exhibited an interest in the problem and has published several pamphlets dealing with health insurance.

It looks, therefore, as if compulsory state health insurance is on the way, and we must be ready for collaboration in this great co-operative Social enterprise. In the first place, we should make every effort to see that the recommendations of the Weir Report in regard to the extension of nursing services should be incorporated, when the bills are being prepared, and in the second place, we must secure the machinery for the control and supervision of the nursing services which will be so greatly extended when provincial enactments are made.

A passive attitude to these problems now is a sin against our profession — against the courageous pioneers who preceded us, and especially against those who will come after us. The Survey Report states that it is imperative that there should be a strong nursing organisation capable of making a continous and scientific study of the health needs of the community and of the professional and economic needs of the nurse, with a view to effecting a satisfactory adjustment between these two important factors. To this end, the following plan is recommended:

FEDERAL COUNCIL OF NURSING

This would be a creation of the Federal Parliament if possible, and subject to a Dominion Board of Control on which the Canadian Nurses Association should hold the majority representation. Representatives of the Canadian Medical Association and of leading lay organisations should also be appointed on this Board.

The Council would exercise functions of an advisory, directive, educational, research and integrating nature. Under Section 93 of the

B.N.A. Act this Council, being federal, could scarcely be clothed with powers of a legislative nature; but it would probably serve as the brain, in an advisory sense, of the various provincial councils.

The Council would be composed of only a few officials at the outset. To quote from the Report: "A director, preferably an outstanding woman educationist with a sound knowledge of nursing conditions and problems, would obviously be necessary. An assistant director, who had specialized in research and had training in scientific education, would probably be required. At least one of these officials should be a trained and experienced nurse. Such secretarial aid as was necessary should not prove a heavy item of expense. Should serious opposition to the establishment of a Federal Nursing Council receiving government assistance be encountered, this Council might be formed as a Division of the Canadian Nurses' Association.

PROVINCIAL COUNCILS OF NURSING

These Councils would be created by provincial enactments and would exercise function, with the advice of the Federal Council discussed above, chiefly of an executive and administrative as well as educational nature.

Compulsory registration with these councils of all who care for the sick for hire—including attendants, visiting home helpers, practical women as well as trained nurses—should be adopted.

The prime function of provincial councils would be to organise and supervise the work of private duty nurses and various types of attendants who care for the sick for hire. Private duty nurses, working directly through local or district registries as part of the provincial organisation, could be given continuous employment on a regular salary basis. These district registries would serve as branches of the provincial council, working under the direction and supervision of the latter, and bringing the types of nursing services required to the homes of patients. The adequate placement of these services would be largely conditioned by the studies of local nursing needs made by provincial councils and by the establishment of effective contacts with the medical profession, training-schools, hospitals, departments of health, and with other agencies concerned with the care of the sick.

The question arises as to whether all private duty nurses should be obliged to work under the direction of the Provincial Council of Nurses, and if so, would there be sufficient employment to keep all those nurses continuously engaged. The following aspects should be emphasized:

(a) Nurses who prefer to remain "free-lancers" would be permitted to do so, but patients of the insured class obviously would not engage free-lance nurses.

(b) Medical evidence, confirmed by the laity, shows that the majority of patients in Canada generally who need the services of the trained nurse are now unable to engage those services. It is probable that under a plan of social science insurance all the trained private duty nurses now available could, under an adequately organised and controlled system, be given employment of a reasonably continuous nature.

(c) The Provincial Council and Nursing Registries should supply a scientific Nursing supervision as a reasonable assurance of efficient nursing services.

(d) A Provincial Board of Nursing Control, the creation of

the Provincial Legislature, should be established to advise and control the Provincial Nursing Council. This Board should be free from political intervention and should be as autonomous as a University Board of Governors. As the problems to be dealt with are primarily those of the nurse, her profession should hold the majority representation on this Board. The nurse members might be appointed for a term of years by the Provincial Nurses' Association. The Provincial Government, the Provincial Medical Association and the laity should also be represented on this Board.

(e) The chief duties of the Board would be administrative, including the appointment of the Provincial Director and other necessary officials, such as the Inspector of Training Schools, Supervisors and District Registrars.

DISTRICT REGISTRIES

Registrars should be specifically trained for their work.

The well-organised and efficiently conducted Registry of Nurses should act as a liaison officer between the health needs of the community and the proffered services of the nurse. More and more should the modern Registry attempt to become an impartial and efficient vocational placement bureau. Its chief aim should be to equip itself to select and allot the right kind of nurse to the type of case that can profit most from her specific training, abilities and temperament, and supply constructive leadership for private duty nurses.

These Registries would be under the supervision of the Provincial Council of Nursing and would supply the nursing contacts with various classes of the community. Various types of nursing services should be made available, such as visiting nursing, hourly nursing, daily nursing, special services such as surgical, maternity, pædiatric and so forth.

Registries should be established in the less populous areas — especially those outside of, as well as within, rural municipalities — and the services of nurses made available under controlled and supervised conditions, to the rural population.

. . . . . .

It was generally recognised by the members of the Joint Study Committee that Professor Weir came to his task of conducting the Survey with a completely open and unprejudiced mind. It was interesting to watch, as his investigation proceeded, how the evidence which he collected gradually changed his attitude of neutrality to one of keen and understanding sympathy towards nursing. In the end he emerged as a champion of the trained nurse. Who can doubt it who reads his prophetic words regarding the role of the nurse of the future: "But who else than the trained nurse can possibly be in the strategic position to act as liaison officer between the 'values and virtues' of the old and rapidly passing school of medicine and the scientific efficiency of the new? No one but the nurse is in the field or available for this supreme venture. If she fails, the case is lost by default. Nor can she succeed unless she be competent to carry out in the sick-room the instructions of the modern specialist in the spirit and with the humanitarian touch of the erstwhile medical generalist. Unless she be a woman of superior capacity, thoroughly educated in her art, there can be little likelihood either that the best of the old will be maintained or that the best of the new will be added."

SUPPLY AND DEMAND

By KATHLEEN W. ELLIS, Superintendent, School for Nurses, Winnipeg General Hospital, Winnipeg, Man.

The principal speaker of this session has reviewed certain phases of the Report of the Survey of Nursing Education in Canada and has touched upon pertinent facts dealing with supply and demand. She has described, on the one hand, the inadequacy of the qualified nursing service as available during acute illness to only slightly more than half, or 60 per cent, of the population in Canada, and on the other, the lack of employment as continuously affecting 40 per cent of nurses in Canada.

It is well to bear in mind that these figures have been computed from an analysis made of conditions which existed in so-called normal times, a period between inflation and depression. A true picture, if drawn today, would assume even more serious aspects. The study of supply and demand involves not only the consideration of the relation between the supply of and demand for nurses but:

1. Unemployment
2. Distribution.
3. Provision for the "faithful public servant" who would perhaps gladly make way for younger members of the profession if she was financially able to do so.

UNEMPLOYMENT

Unemployment is a very stern reality in the present day as the result of which the nursing profession, in common with others, has faced and will no doubt have to face still greater difficulties.

On good authority it is stated that in a reputable hospital in the United States of America nurses are working, thankful to have employment, for $10.00 a month and their maintenance. In yet another institution, the hospital authorities were forced to renounce all responsibility for salaries, merely dividing any surplus, after all bills were paid, on a pro rata basis, among the employees, including members of the nursing staff. It is announced that only two resignations were received as a result of this drastic change in policy and that, after operating for nine months on this basis, the employees are now receiving 70 per cent of their original salaries. When such conditions exist perilously near home, should we not be roused to take action?

The Director of the Survey, in dealing with the whole question of supply and demand and particularly this phase of it—unemployment — emphasizes conditions as they exist for the private duty nurse. Generally speaking, a nurse, if she continues in the profession, becomes a private duty nurse, not only as soon as she ceases to be a public health or institutional worker but between engagements of a continuous nature and automatically as soon as she is unemployed. Therefore, it is apparent that the problems of the private duty nurse are those not only affecting most directly all members of the profession and the community but ones which may affect any individual member of the profession at any time. We do well to bear this in mind.

It is stated in the Report that several factors enter into the question of unemployment, *i.e.*:

1. Oversupply

2. The competition of the practical nurse
3. Distribution
4. Last, but not least, the "quality" as well as the "quantity" of the nurse permitted to graduate and pass or, in many instances, be *pushed* through, what is referred to in the Report, as "the large meshes of the R.N. examination net."

The latter factor, together with the problem of the practical nurse, has been dealt with elsewhere. Regarding the former, the Director of the Survey states that if some better method for discrimination had been used, "the present percentage of student nurses now in training, who will probably graduate as inefficient or mediocre nurses and swell the ranks of the unemployed, would have been advised to adopt a type of work more congenial to themselves and more beneficial to the community.

Superintendents of Nurses take note! While not minimizing the value of more personal effort on behalf of the less apt student, which has already been advocated by a former speaker, I, for one, am truly more apprehensive about the "misfits" whom I have been instrumental in placing *within* the profession than those *without,* for whom I have similar responsibility. It is possible that, in the day of reckoning, Superintendents of Nurses will be called upon to answer for these misfits? If this is to be the case, it is but slight consolation to feel that one will not stand alone!

That standards in schools of nursing and requirements for registration of the nurses must be raised is obvious. Also the quality of the nurse is affected by the preparation. Much has been said already on this subject. The Report recommends interneship for the student who proposes taking up private duty nursing, this to be taken during the course of training if and when much of the spade work, now being done in the school of nursing, has been relegated to the high school preparation of the candidate. For institutional nurses, supervisors, head nurses and all those taking part in the education of the student, Dr. Weir states preparation covering a period of five years is essential.

In spite of continuous and increasing conditions of unemployment, is it not true today that positions, calling for women specially qualified as teachers, supervisors of departments—such as the operating room, public health workers and even private duty nurses for special cases—are extremely difficult to fill. Registries, it is stated in the Report, show a need for well trained nurses to care for contagious, nervous and mental and pædiatric cases.

Distribution

This plays an important part in supply and demand and is one more contributing factor to unemployment. Again it is pointed out in the Survey Report that the intelligent woman, with resources within herself, makes the best pioneer. The recommendations in this connection are that more careful consideration be given to the relationship between the needs of the community and the number of nurses graduated and that some form of adequate supervision be provided.

One would like to stress here the value, especially to the young graduate, of experience in the so-called small hospital but no longer in either small or large hospitals should students be admitted only because the hospital needs them. The Weir Report deals very definitely with obligations of the hospitals in this connection and most aptly points out that the employment of more graduate nurses on the staff of hospitals is one of the

solutions of the unemployment and overcrowding in the field of private duty. A closer co-operation between hospitals, large and small, is very essential in the realisation of this and many other common objectives.

"Hospitals should assume more responsibility for the entire nursing care of patients of average means," states the Director. While this would mean a reduction in the number of 'specials' engaged by hospital patients, it would also mean an addition to the graduate staff of the hospital." One does not wish to underestimate the service rendered by the private duty nurse, who comes as a blessing to the family and to the hospital, but it is interesting to note that the special nurse is frequently not employed in the hospital by the patient, whose actual condition demands the maximum amount of nursing care.

The psychological factor, its influence on patients, relatives, friends and even supervisors, plays an important part in many instances. One questions, therefore, whether even a very definite increase in the number of graduate nurses employed in hospitals would seriously interfere with the number of special nurses who probably will continue to be employed by the patients who, for various reasons, demand this type of service.

Dr. Weir recommends "a gradual reduction of about one-half in the student personnel and states that the proportionate increase in the number of paid graduate nurses added to the hospital staffs should be aproximately 56 per cent of the above reduction." Also, the further development of group nursing and hourly nursing has been recommended.

The advantages of graduate nurse service to patients, hospitals and nurses cannot be overestimated, but those who have been confronted with the problem of replacement may venture to question the proportionate numerical value implied in the above recommendation.

It will be well, when placing this scheme before Boards of Trustees, if definite figures can be provided to prove that such a change of policy will result in a reduction of cost to the hospital.

Supply and Demand

Several recommendations, dealing indirectly with the subject of this paper, have already been submitted. There remains two which, in concluding, I wish to present for your consideration:

1. That Hospital Boards be circularized by Provincial Nurses' Associations regarding the desirability for a reduction of 50 per cent in the student nurse personnel and for whatever increase is necessary on the staff of graduate nurses.

In forwarding this letter, it is recommended that the attention of hospital authorities be called: (a) To the suggestion in Dr. Weir's Report whereby such a change in the personnel of the nursing staff might well be regarded as a reason for a slight increase in fees on the part of the hospital, and (b) the possibilities of further development of group nursing and post graduate work.

2. That Provincial Joint Study Committees be asked to make a special study of a superannuation scheme for nurses.

It has been said "that the reward of business for service rendered should be a fair profit, plus a safe reserve commensurate with the risk involved and foresight exercised." Surely the nurse is entitled to as much—a fair profit sufficient to permit of a safe reserve to protect her in illness, or advancing years, and commensurate with the foresight which she has exercised in securing preparation for her chosen profession.

SOCIALISED NURSING

By ELEANOR McPHEDRAN, Superintendent of Nursing, Central Alberta Sanitorium, Calgary, Alta.

The subject assigned to me has so many angles that I was at a loss to know just what might be the best point of attack in presenting the topic for your consideration. You, Madam Chairman, suggested that we find out what has been done on the subject of Health Services and Health Insurance. This is only a sketchy outline but if it will direct the thoughts of the nurses to the opening up of new fields of activity or the extension of old fields, I shall be very glad. I feel keenly my limitations. I am not a public health nurse in the accepted sense, but it has always been my nursing creed that all nurses should be teachers of health —therefore, public health nurses in the broadest meaning.

Sir Arthur Keith is quoted as follows: "We cannot escape state control in the long run—however much we may regret the loss of personal liberty which is thereby entailed. We may mould circumstances to our wills on some occasions, but in the most we are carried along on the irresistible current of affairs, the main feature of the law of evolution is its inexorability." There is beyond question both within and without the medical and nursing professions an ever increasing demand for such re-arrangement of social affairs as shall permit greater co-ordination of the available services with the community needs.

The principle of Socialised Nursing is essentially bound up with the wider topic of "State Medicine" or "State Health Services," for one cannot conceive nowadays of any health programme which does not increasingly demand the service of the nurse. She has her very definite and universally recognised part to play in the development of any scheme of health service, whether that be a voluntary organisation as the Victorian Order or Red Cross; a Corporation Service as the Metropolitan Life; Municipal Organisations which require School and Health Department Nurses; Provincial Health Departments, with their varied activities. In spite of all these fields there is still this 40 per cent nursing service unemployed and the 60 per cent of community nursing needs not met. Also there is the severe handicapping of hospitals through the financial burden in caring for the indigent, and much more serious, there is the reluctance of people of moderate means to consult medical men or seek relief from suffering through lack of ability to pay.

One of the very urgent recommendations made by the Survey Report for the meeting of the needs of the people of moderate means in health measures, is the establishment of Health Insurance, province-wide in scope, and this solution of the problem is rapidly growing in favour, more especially in the Western Provinces. It is interesting to note what has been under consideration there during the past two years.

In Manitoba there was introduced into the Legislature in 1931, a resolution asking that the Minister of Health and Public Welfare be requested to make a comprehensive enquiry on:

(1) Preventive Medicine.
(2) Municipalization of Medical and Hospital Services.
(3) Logical Health Areas.
(4) Health Insurance and other practical methods for the more equal

distribution of the cost of illness.

(5) Public Medical Services.

(6) Practical methods for making specially required methods of diagnosis and treatment more readily available.

A special committee of the House was appointed to co-operate with the Minister in formulating a comprehensive health scheme for the Province, with a view to providing more efficient and economical Public Health Service.

The findings of this committee are most interesting, not only from a community point of view but also from the point of view of the nurses. All evidence pointed to one general principle: *That the cost of illness should be provided for in advance of illness and that the cost should be so distributed that it bears equitably upon all.*

The findings for Sections

(1) Preventive Medicine

(2) Municipalization of medical and hospital services

(4) Health Insurance

and

(5) Public Medical Service

concern us most closely.

In Section 1, Preventive Medicine —and please note that preventive medicine is put first—is recognised as primarily a municipal and provincial responsibility, but the committee recommends that, for reasons of economy and efficiency it be carried on in conjunction with Curative Medicine.

Section 2. Municipalization of Medical and Hospital Services. It is considered that in rural districts the work might be carried on more feasiblv under the taxation method. This method of meeting expense is its greatest drawback as the increase in taxation, however slight, is apt to be met with disfavour by the ratepayers. But the establishment of a Health Insurance Plan was considered too costly for the sparsely settled district. There would be urgent need for the education of the public so served.

With the municipalization of health service is recommended the development of an adequate visiting nurse service enabling the patient to be visited in the home and cared for there in minor illnesses, thus reducing the number of cases for hospital treatment, and consequent hospital costs.

(3) Health Insurance in some form is strongly recommended in urban areas — the details to be worked out on an actuarial basis.

(5) Public Medical Services. The responsibility for certain public medical services, notably those for mental diseases and tuberculosis, should be left as at present — under provincial control with accentuation of follow-up work and increase of clinic services as conditions permit.

In all phases there was a recognition of the value of nursing service involving an increasing demand as the programme developed. Again I call your attention to the fact that Preventive Medicine is given first place in the list.

In Alberta some four years ago a Commission was appointed to inquire into "Systems of State Medicine." After an exhaustive study of the systems in vogue in Great Britain, France, Germany, the United States, Australia, New Zealand and the various Provinces of Canada, certain recommendations were made to the Legislature. As in Manitoba, Health Insurance was recommended for the urban areas, the service provided to include medical, surgical, specialists, dental and hospital treatment, nursing, medicine and appliances in cases of sickness, maternity benefits for insured women and the wives of insured men and cash benefits in case of sickness if desirable; the system to be worked out somewhat on the lines of the Workmen's Compensation Board; the total cost to be

borne by employer, employee and the province in the ratio of two-fifths, two-fifths and one-fifth respectively. The approximate cost to the insured would probably work out to about $1.00 per month.

For the rural areas the taxation method was favoured. It was recommended that the nucleus for a rural medical centre exists in the municipal hospitals established throughout the province — that physicians be placed on salary and that the cost be met by taxation. It was computed that the cost would average about $4.50 per capita annually. Since this report was given the municipal hospitals have had very trying times in meeting obligations. In many cases crop failure has been such that hospital taxes could not be met, though the need for hospital care was just as great. No mention is made in the above of nursing measures except as implied in hospitalization but, as I said before, it is next to impossible to conceive of pre-natal and post-natal work, of pre-school and school work, in short of any preventive work being carried on without supervision and instruction, both of which a physician is much too busy to do.

Further, a very considerable space is given in Section IV to the public health point of view. May I quote from this: "While neither of the schemes outlined is expressed in terms of public health, it is implied in both. They are proposed, supported and defended on the ground that they will promise public health," and after a brief resumé of the report on National Health Insurance in Great Britain, 1926, "There are grounds for believing that expenditures on health, unless primarily directed to the removal of the causes of ill-health, may tend to occasion a further increase in expenditure," and again: "The great gain in public health during recent decades has been due to the application of the principle of preventive medicine, the actual prevention of disease." Does not the nurse find her place here?

In the 1932 meeting of the Legislature, a resolution was unanimously adopted calling for a commission to consider and make recommendations at the next session of the Legislature:

(a) As to the best methods of making adequate medical and health service available to all the people of Alberta

(b) To report as to the financial arrangements which will be required on an actuarial basis to ensure same.

British Columbia has gone a step further so far as health insurance is concerned. The final report of a Commission on State Health Insurance and Maternity Benefit was brought down this Spring (1932) and published for distribution. In this report five alternate plans are given for Health Insurance with varying costs. These were figured on a basis of two-ninths to the State, two-ninths to the employer and five-ninths to the employee. Allowing from eight to ten per cent of the fund for administrative purposes, the cost to the insured person varied according to the extent of benefit from 62 cents per month to $1.93 per month. In the more expensive plan benefits were allowed for dependents of insured and cash allowances for maternity benefits and for time loss of insured. Little mention is made directly of nursing service or of preventive medicine.

One rather vague paragraph, 218 of the summary of recommendations, reads: "That the accumulated funds of surpluses be invested in the extension of social services for insured persons, such as providing for the inclusion of dental, ophthalmic and other beneficial health measures, including the establishment of clinics, laboratory aids to diagnosis, and periodical health examinations; or otherwise as may

be deemed advisable." In the last paragraph of the conclusion we read: "With the development side by side with the curative measures, of a sickness preventive service, an ideal system will be set up for the effectual handling of what may be described as the greatest benefit to mankind—the maintenance of good health."

Growing out of this brief resumé of the activities looking toward State Health Measures and Health Insurance is this resolution which I leave with you for discussion:

"Resolved that the Canadian Nurses Association recommend that the Provincial Joint Study Committees be asked by the Provincial Nurses Associations to wait upon the official bodies concerned with compulsory health insurance (in the provinces which already have it under consideration) with a view to impressing upon these bodies the necessity of socialising nursing services, as recommended in the Weir Report.

DOMINION BUREAU OF NURSING, PROVINCIAL BOARDS OF CONTROL, DISTRICT REGISTRIES

By A. J. MacMASTER, Superintendent, School for Nurses, Moncton Hospital, Moncton, N.B.

I am sure that Dr. Weir has so thoroughly covered this matter in the Survey Report, and his findings and recommendations have been so excellently abstracted and reviewed by competent critics through the media of medical and nursing journals, as well as the lay press, that any attempt on my part to enlarge upon the subject, or offer suggestions, is presumptuous. I shall confine myself briefly to pertinent facts covering the proposed inauguration of the Dominion and Provincial Bureaux of Nursing, and conserve valuable time for discussions thereon.

Inquiries from authoritative sources in the United States, such as the Committee on the Grading of Nursing Schools, The National Health Library, and a study of literature dealing with the former, elicit the information that there exists the same picture of overproduction and unemployment, of inequality in educational standards, and of multiplicity of inferior schools, while to offset this testimony there is ample evidence of schools doing excellent work, and leaving a firm conviction that broadly speaking, nursing is (in spite of all its troubles) "sound at the core." A foremost American authority offers the opinion that a year from now, there will be forthcoming not only a diagnosis but a prescription for treatment.

It would appear to be the privilege of the Canadian Nurses Association to break the first soil for the cultivation of a definite national standard. Dr. Weir has brought to it, in his Report, not only a comprehensive digest of existing difficulties, but recommendations as to corrective measures, which, properly developed, will give us a compass for guidance that will be unparalleled in Nursing history.

Unfortunately, the problem has matured at a time when the country is suffering from an economic depression most seriously complicating the financial aspect about which the entire scheme revolves; while endorsing the Weir Report without reservation, we must (unless an endowment is procured wherewith to proceed without restriction) carefully analyse the Re-

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port and select from it sufficient material to lay a solid foundation upon which we may build the ideal nursing service of the future.

A DOMINION BUREAU OF NURSING

The keystone of this structure should be the creation of a Dominion Bureau of Nursing, brought into being by the Federal Government. Dr. Weir suggests two bodies (a) a Dominion Board of Control and (b) a Federal Council of Nursing, to manage the national affairs, but for the purposes of the Canadian Nurses Association the functions of two such Boards could be assembled in one deliberative body named above. It should never leave the control of the Canadian Nurses Association, and, therefore, should be made up of approximately two-thirds membership derived from the various nursing organisations, and with fair representation from every province to avoid discrimination. Other appointees to the Dominion Bureau of Nursing should be representatives from the Canadian Medical Association, the Federal Government, the Victorian Order of Nurses for Canada, and the Canadian Red Cross Society. It might be advisable to include lay organisations, for example, the National Council of Women, and authorities on sociological problems from the universities.

Details immediately associated with its administration, such as officers, term of office, number of members, etc., could be best left in the hands of the National Joint Study Committee, which committee would form the nucleus of the Bureau.

The function of this Bureau should be to establish, among other things, a national standard for schools of nursing in Canada, including the educational standard of the student seeking admission thereto, and otherwise conforming to Dr. Weir's recommendations. It should be responsible for the establishment of a national curriculum, and should originate Dominion Nurse Registration Examinations, the gaining of which would automatically entitle the candidate to inter-provincial reciprocity. Other functions would include educative, advisory and administrative measures. Its recommendations would be accepted as the criterion for the Provincial Bureaux of Nursing.

A PROPOSED SCHEME TO FINANCE THE DOMINION BUREAU OF NURSING

1. Appropriate the Memorial Fund Surplus, "to assist financially any enterprise which will benefit the whole nursing profession in Canada." (Extract from Resolutions passed at C.N.A. General Meeting, July, 1928.) This balance, as at March 31, 1932, was $1,618.52. This would prove, indeed, an ideal memorial!

2. The financing of the Dominion Bureau of Nursing might be patterned after that of the Medical Council of Canada, established in 1912 under the Canada Medical Act. This Council derived its administration expenses from the revenue received through fees paid by physicians for the privilege of securing Dominion Registration. The provisions of the Act entitled registered physicians in active practice for a stated period of years, at the time of the passing of the Act, to Dominion Registration upon payment of a fee of one hundred dollars. This precedent might apply to registered nurses holding certificates in one or more provinces or states, and who by virtue of their experience gained through years of active practice, coupled with post-graduate study, have earned similar recognition in their particular field. Nurses graduating after the establishment of the Dominion Bureau of Nursing would be required to write examinations upon payment of a scheduled fee. The proceeds from such registration fees should yield considerable

revenue with which to administer the Bureau.

Provincial Machinery

The Provincial Bureau of Nursing should be an enactment of the Provincial Legislature and should be composed of two separate bodies (a) a Board of Nursing Control to guide the destiny of (b) the Provincial Nursing Council. The Board of Nursing Control would have the power equivalent to a University Board of Governors, and not subject to political interference. The majority of this Board should consist of nurses appointed by the Provincial Registered Nurses Association for a term of years, a rotating term being advisable to ensure the presence of members with a working knowledge of its functions. At least one nurse member of this Board of Control should be appointed to the Dominion Bureau to act as a liaison officer. Other members of the Board should be representatives from: the Provincial Medical Association, the Provincial Government, and the laity, preferably an educationist.

The appointments from the Nurses and the Medical Associations should include the members of the Provincial Joint Study Committee. Public health, institutional, private duty, and educational sections should all have representation on this Board.

The Board of Control would be correlated to the Dominion Bureau of Nursing, and should be answerable to the Dominion Bureau for the maintenance of the high standards of efficiency set down by that body.

The financing of this Board would be negligible since the members would act in an honorary capacity only.

Subordinate to the Board of Control would be the Provincial Nursing Council, consisting of salaried officers who will actually execute the nursing affairs of the Province. The recommended personnel of this Nursing Council includes a director, possibly an assistant director, a registrar, a clerical staff as required, an inspector of schools of nursing, and field supervisors.

The financial burden of this Provincial Council would seem at the present time almost insupportable in many provinces. Unless the governments can be induced to subsidize the project, or until some form of health insurance provides funds therefor, it must be handled by each province as an independent problem. Any province able to install the full machinery should have power to proceed; other provnces should be encouraged to select the officers most urgently needed until they can acord a full staff. Every province, regardless of resources, should engage, as the first and most important step, a thoroughly qualified inspector of schools of nursing. Two or more provinces might share the services of one inspector until such time as each province could finance independently.

Compulsory Registration

Compulsory registration for all who care for the sick for hire, should be the prime responsibility of the Provincial Bureaux. Some definite provision must be made for those already in the field, whether graduates or undergraduates. During this acute period of unemployment, and in an already overcrowded field, it is my personal contention that it would seem fair to concentrate on the relief of the graduates of any hospital, large or small, poorly- or well-trained, before we turn the searchlight on the vicarious problems of under-graduates and allied workers, or increase their ranks by encouraging short courses.

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario

Provincial Registration Examinations

These have been referred to by Dr. Weir as a "sieve with open meshes." They involve two problems:

(1) The questioned precision exercised by Boards of Examiners in evaluating examination papers.

(2) Widely divergent standards of the schools of nursing which produce the candidates seeking registration.

Many factors complicate the situation, for example: Marked diversity of admission to schools of nursing; limitations in training courses; lack of affiliations; faulty preliminary education, and fundamental lack of intelligence.

All these must be considered as equally responsible for our vulnerable position, rather than any intrinsic failure on the part of Boards of Examiners to perform conscientiously their duties. Until such time as the Dominion Bureau of Nursing establishes a national standard for schools of nursing, which would include entrance requirements equivalent to university matriculation, and until a standard curriculum eliminates the varied courses of the present system, no better method would appear to be forthcoming. Corrective measures would seem to indicate the employment of a trained examiner in each province for the rating of all examination papers. Toward this end we might seek the assistance of a university within each province. Supplementing this, it might be possible to arrange with the universities to apply intelligence tests to applicants seeking to enter schools of nursing.

District Registries

We must acknowledge the inadequacies of the present system of registries. There must be, at some time, definite provision made for the installation of district registries as discussed in the Survey Report. However, until the Dominion and Provincial Bureaux are actually functioning, discussion thereon is pre-mature.

. . . . . .

Mindful of the above, it is my privilege to submit the following

Proposed Resolutions on Section (3) of "The Distribution of Nursing Services"

Be it therefore resolved that the Survey Report, insofar as it pertains to a Dominion Bureau of Nursing, Provincial Bureaux of Nursing and District Registries be endorsed, and that the following action be taken in respect to:

(1) Dominion Bureau of Nursing

That the National Joint Study Committee be asked by the Canadian Nurses Association to petition the Federal Government to create a Dominion Bureau of Nursing as recommended in the Weir Report.

(2) Provincial Bureaux of Nursing

It is recommended that Provincial Associations ask the Provincial Joint Study Committees to petition the Provincial Governments:

(1) To create Provincial Bureaux of Nursing as recommended in the Weir Report.

(2) To enact compulsory registration of all who care for the sick for hire.

THE DISTRIBUTION OF NURSING SERVICES

Resolutions adopted by the Canadian Nurses Association following the presentation of papers with discussion on The Distribution of Nursing Service — The Survey of Nursing Education in Canada are:

1. THAT Hospital Boards be circularized by the Canadian Nurses Association regarding the desirability for a material reduction in their student nurse personnel, and whatever increase necessary in the staff of graduate nurses.

2. THAT Provincial Joint Study Committees be asked to make a special study of superannuation schemes for nurses.

3. THAT the Canadian Nurses Association recommend that the Provincial Joint Study Committees be asked by the Provincial Nurses Associations to wait upon the official bodies concerned with compulsory health insurance (in the provinces which already have it under consideration), with a view to impressing upon these bodies the necessity of socialising nursing services, as recommended in the Weir Report.

4. THAT the National Joint Study Committee be asked by the Canadian Nurses Association to study the question of a Dominion Bureau of Nursing as recommended in the Weir Report, and report back to the Canadian Nurses Association.

5. THAT the Provincial Associations be asked to instruct the Provincial Joint Study Committees to study the question of petitioning the Provincial Governments to enact compulsory licensing of all who give nursing care to the sick for hire and to report back to the Provincial Associations for action.

THE TREATMENT AND PREVENTION OF COLDS

By G. HILTON, M.D., Department of Oto-Laryngology, The Montreal General Hospital, Montreal, Que.

The word cold as used by the laity is a rather vague term, but is rendered somewhat more specific by the commonly-used phrases — head colds and chest colds. Althought these terms convey to most people a definite condition, they yet may embrace many conditions of a different nature. Most respiratory infections may at one time or another during their course be classified under colds. However, in the vast majority of cases the common cold is an acute rhinitis with swelling and inflammation of the mucous membrane of the nose and often accompanied by a slight involvement of the nasal accessory sinuses.

Symptoms

A cold often commences with a tickling sensation in the nose and sneezing. The nose soon becomes blocked and there is a copious watery discharge which later becomes purulent. The nasal obstruction impairs the sense of smell and taste. Breathing through the mouth causes a dryness and irritation of the respiratory passages. Headache, malaise and often a slight rise in temperature are the usual results. The common cold in most cases subsides within a week or ten days. Some colds, however, do not subside, but lead to disease of the nasal accessory sinuses, ears, larynx, trachea or bronchi. On the other hand the early stages of the disease may be similated by the exanthemata, influenza, asthma, nasal syphilis, nasal gonorrhoea, etcetera.

The ordinary cold in the average healthy child or adult is not a serious thing, but may be of grave import in infants by interfering with nursing, or in the aged who have not the resistance of youth.

Local Condition

The examination of the nose at the time of a cold reveals a mucous membrane which is very red, turgid and swollen. The depths of the nasal cavities cannot be seen without the shrinking action of cocaine and adrenalin, due to the almost if not complete blocking of the nose by the engorged turbinates and mucous membrane. There will be a copious serous or purulent discharge present according to the stage of the disease at the time of examination and more or less excoriation and reddening of the skin around the nose due to the irritating discharge.

Treatment

Many colds could be aborted at an early period if the person afflicted were to remain in bed for a few days and follow treatment. A good hot bath and brisk rub down before going to bed followed by hot drinks and some diaphoretic, like Dover's Powders, is very beneficial. The bowels should be freely opened by a laxative followed by a saline cathartic the following morning. Inhalations of steam with a little tincture of benzoin or menthol often gives considerable relief, especially when the cold is associated with a laryngitis. The patient should be in a well lighted and ventilated room with plenty of covers on while in bed. Hot fluids only for the first day or two are advisable.

Some solution containing adrenalin or ephederine used locally as a spray or as nasal drops gives considerable comfort by relieving the congestion in the nose for the time being.

℞

Menthol
Camphor a.a., 2 grs.
Ephederine Hydrochloride, ½ dr.
Albolene ad, 2 oz.

Sig:—

Use as a spray or nasal drops.

Local applications of silver solutions such as 5% or 10% neosilvol is highly recommended by some. The value of vaccines during the acute stage of the disease is questionable.

Prophylaxis or Prevention of Colds

Any pathological condition in the upper respiratory tract may predispose to colds by acting as foci of infection or by interfering with the normal functions of the nose and throat. The local and often the general resistance is thereby lowered favouring invasion. People who suffer from frequent colds and who have infection in the tonsils, adenoids or sinuses, or who have nasal deformities which prevent proper nasal breathing, should have these conditions attended to.

As everyone knows, the common cold is very infectious. When one member of a family contracts a cold it is quite usual for other members of the same family to become likewise afflicted. Therefore people with colds should be very careful in their contact with others. All nasal discharges should be collected on lint or cotton and burned or otherwise destroyed. Babies should especially be protected from people suffering from a cold as babies are very susceptible to colds and prone to develop the complications following colds. The transference of a cold to others is best avoided by having the patient confined to bed for the first few days of the disease. The infectious aspect of a cold cannot be traced to any one organism but usually a combination of organisms with one predominating is the rule.

Many observers have pointed out that people more or less isolated in out of the way places and yet subject to all the predisposing causes do not suffer from colds. This is probably due to the lack of an in-

fecting agent. However, when these people come to our crowded centres of civilisation where colds are prevalent, they are very prone to develop colds, even though the predisposing causes may here be lessened. Thus one may assume that where there are crowds there are colds and to avoid colds avoid crowds.

The general resistance is a big factor in one's immunity to colds. Anything tending to lower the general resistance should be avoided and that which tends to increase the general resistance encouraged. Fresh air and sunshine are two essentials for the maintenance of the general resistance but unfortunately many people are deprived of this necessity by the very nature of their occupations and mode of living. During our long winter days in this country people with indoor occupations have little opportunity to be out in the sunshine and in many places they are subjected to an overheated, dry and vitiated atmosphere. Where time and opportunity offers, walking to and fro to work instead of using a public conveyance will help to remedy this evil. At least an hour of walking per day in the open should be the minimum. In many offices and homes the air is too warm and dry and not in circulation. The proper room temperature should be comfortable and in the neighbourhood of 68° F. Steam heating is preferable. The air should be fresh, in circulation and kept moist by having water in containers where evaporation can take place. The bedrooms should be bright and well-ventilated with the windows open during the sleeping hours. During the winter months when there is so little sunlight, a course of quartz light treatments helps to increase the general resistance if one is able to afford the luxury. Many of the larger hospitals to-day make quartz light therapy available to their staff, internes and nurses as it raises their resistance to infections.

Exercise is important especially to those people living a sedentary type of life. This should preferably be taken in the open. If games are indulged in the clothing should not be too heavy and at the conclusion of the game when the participant is cooling off, a coat and cap should be worn. A hot bath or shower with a brisk rub down should follow. For those unable to participate in games walking is very beneficial.

Excesses of alcohol and tobacco should be avoided as they are very irritating to the mucous membrane of the respiratory tract, thereby lowering the local and general resistance of the body. Sufficient sleep and rest are essential. Errors in diet and over-indulgence in any way should be guarded against. The use of vaccines as a prophylactic measure have been very successful in some cases, although other cases seem to derive no benefit from vaccine therapy. R. Vance Ward, after three years' experience with vaccination against the common cold in a number of health services in some of the leading industries in Montreal, concludes that the stock vaccines, although not specific preventatives of acute respiratory disorders, nevertheless benefit a large percentage of people.

In conclusion one might say that the common cold is a world-wide disease not being confined to any special geographic distribution, nationality, age or sex. It is usually treated in a trivial way, often causing little inconvenience to the afflicted person, but at times producing serious and surprising complications. The incidence of the disease can be considerably decreased by proper preventative measures and the results of the infection minimized by appropriate treatment.

THE TRAVELLING CHEST CLINIC

Province of British Columbia

By J. B. PETERS, Tranquille Tuberculosis Society, Kamloops, B.C.

Some time ago a physician was appointed by the British Columbia Government to act as Travelling Health Officer and assist the doctors in the smaller centres of the province in finding and diagnosing cases of tuberculosis in as early a state as possible.

It was not until the fall of 1928 that the Tranquille Tuberculosis Society, with funds raised by the sale of Christmas Seals, purchased a portable x-ray and provided a public health nurse to assist in this work. All expenses in connection with the x-ray, the nurse's salary and travelling expenses are paid by the Tranquille Tuberculosis Societv.

On commencing her duties the nurse spent a month at the Tranquille Sanatorium getting acquainted with the patients there, finding out about their home conditions, the number of contacts in the home, and any other information that might be of assistance in the finding of new cases.

Also, a list was made of cases discharged during the previous three years, and of those who had died, with all the information available. These names and information were segregated into a loose-leaf book indexed under the different towns. A search was also made in the Provincial Statistical Department of the death certificates for those dying of tuberculosis; all old records of the Travelling Health Officer were thoroughly searched, listing those with tuberculosis, all contacts, suspects and pleurisy cases, with date of last examination. This information was added to the loose-leaf book.

This book is carried to each and every clinic, the lists checked over with the doctors and public health nurses, and arrangements made for rechecking former patients where necessary and getting the contacts in for examination. Contact cases are examined once a year whether they are negative or not: if there is anything suspicious they are returned to each clinic.

X-ray plates are taken of practically every new case, but old cases are taken on recommendation of the clinic doctor only.

Up to the time of the appointment of the nurse, and the addition of the x-ray, the clinics were held in the doctors' offices, or cases visited in their homes or in hospital. Now the clinics are held in the various local hospitals. The lady superintendents of the different hospitals cooperate very kindly, usually providing two or more rooms for the use of the clinic. The developing plant in the hospital is used, where there is one, if none the films are taken to the next centre for development. The films are left in the hospital where taken, and are available for comparison on succeeding clinics, or to the doctors if they wish.

THE DUTIES OF THE NURSE

1. The nurse is responsible for the taking of histories of all new patients. (A complete personal history is taken of each patient on their first visit to the Chest Clinic.)

2. She sees that (a) patients are admitted to the doctor for physical examination in their proper rotation; (b) all new patients are x-rayed and old patients returned for x-ray after physical examination; (c) films are developed, also marked and arranged for reading.

3. After the clinic is over, reports of each case are written for the family doctor, and reports and history cards filed. This latter is all done in Victoria.

4. The aforesaid loose-leaf book is kept up to date. New cases are listed and any changes in diagnosis noted, also the date of last examination is written in pencil of cases already listed, so that when the nurse returns to any centre it is an easy matter to remind the family doctor or public health nurse of any cases that should come in for rechecking.

5. A trip is made to the Tranquille Sanatorium whenever possible in order to keep in touch with the patients there, and admissions and discharges noted.

The Finding of Cases

This is attempted in various ways:

1. Before a clinic is held in any centre a notice is put in the local paper stating that clinics are to be held on a certain date, that examinations are free, but asking that arrangements for examination be made through the family physician.

2. Through the local doctors, who are always willing and seem pleased in most instances, to check over the nurse's list of previous cases and arrange to send in any contacts or other patients that should be rechecked.

3. Through the public health nurses. In many places the public health nurses have arranged the entire clinic and made appointments before the Chest Clinic arrives. These nurses, of course, are working closely with the doctors.

Clinics are held in practically every town of any size in British Columbia, with the exception of Vancouver; all over Vancouver Island; from North Vancouver to the Alaskan border, and the interior to the Alberta border and north to Prince George, Hazelton, etc. This means a lot of travelling. Some parts of the province are covered only once a year, others every two to six months. On a recent trip through the Kootenay and Crow's Nest district approximately twenty-seven hundred miles were travelled with two hundred and eleven cases examined in a little over four weeks. Of course this is an exceptionally scattered area.

Clinics are growing continuously, as the following figures will show: Total examinations: 1929, 991; 1930, 1,779; 1931, 2,323; 1932, 2,950. The statistical year ends August first.

In recent years on account of the alarming number of nurses who have broken down with tuberculosis, an effort is made to examine all the graduate nurses on the staff of each hospital. The nurses in training are done as a routine procedure. A number of unsuspected early cases of tuberculosis have been found in this way, but it is still difficult to persuade the graduate nurses that they should be examined. Often they will come in and be x-rayed when they will not consent to a physical examination, and there have been several that have been first diagnosed on the x-ray findings.

Before closing this article references must be made again to the public health nurses. Their unfailing keen interest and kindly help in these Chest Clinics have been invaluable. They not only look up cases and arrange clinics, but they assist in every way possible with the clinics while in progress. Needless to say it would be impossible for the travelling nurse to attend to everything in some of the larger centres.

The travelling nurse would have not only a difficult task, but a lonesome time away from home were it not for the public health nurses and the lady superintendents of the various hospitals.

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
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THE INTELLIGENCE AND EDUCATION OF THE STUDENT NURSE

By MAUDE M. WRIGHT, Montreal, Que.

A great difficulty arises when an attempt is made to arrive at an improved method of selection of the student nurse. We think of the nurses of the past—grand, courageous women, with a history of self-sacrifice and endurance. The pioneer work of Jeanne Mance and Madame de la Petrie who, 300 years ago, left homes of comfort in the Old World and established hospitals at Quebec and Montreal, has given to the world the example of service embracing three centuries of Canadian history. At that time nursing was entirely in the hands of religious orders whose devotion to duty in the face of the most trying hardships and discomforts is even remarkable to this day. The tradition of loyalty and service has descended from those brave pioneers to present day nurses. Although "much water has flowed under the bridge" since those early days, yet the same characteristic essentials are needed to make the successful nurse if she is to acquit herself with honour, and add to the high ideal of the nursing profession.

What does the medical profession and the public require in a nurse? Are these requirements reasonable and progressive? What is the best method of training which will produce nurses capable of meeting these requirements? And, finally, what type of individual furnishes the best material as a foundation upon which this training is to build? These are unanswered questions that require a great deal of thought and consideration. "Necessity is the mother of invention," and "the demand creates the supply" are old adages. This generation has has two great crises: the World War and this depression—which requires even a greater courage to face. Both have brought about the emancipation of women, and many women are seeking a career in the world whose grandmothers would be shocked at even the suggestion of such an undertaking. "Blessed are the uses of adversity" is one of the proverbs, and it may be that we, as nurses, may be able to reach out and serve the sick to a greater extent than formerly, and all branches of the profession may be drawn more closely together to serve a common cause.

In my humble opinion, four essentials are necessary characteristics of the pupil nurse. One must remember that what is in the nurse-in-training will survive and grow in the graduate. The first essential is *Aptitude;* the second, *Loyalty;* the third, *Service;* and the fourth, *Education.* I put education last, for without the first three—aptitude, loyalty and service — education is

(Read at the Private Duty Nursing Section, Canadian Nurses Association, General Meeting, June 23rd, 1932.)

of little account. It may make the mechanical nurse, but that is not the highest ideal of the nurse. Let us deal with each separately:

Aptitude: Sympathy towards the down and out, physically and mentally; a quiet, reassuring presence. Some nurses are all heart and no head. Both are necessary, and yet each one may be a successful unit in the nursing profession. A nurse who would make a muddle of caring for a sick, nervous patient may become an excellent head nurse. She likes detail, can command others, can impart her knowledge to others. The nurse who can be versatile, meeting different types of patients, supplying what they lack, for truly the nurse feeds the mental as well as the physical condition of her patient, and carries them on to recovery. Both types of nurse are needed. Each fills her own place. And so, although the aptitude may differ according to the individual nurse, yet it must be there. Aptitude in caring for the sick is a very essential quality.

Loyalty. By loyalty I mean loyalty to those with whom the student nurse comes in contact: to the head nurse, to the patient, to one another, and to the doctor. I put the doctor last in order, for to the nurse-in-training the doctor does not come greatly into her nursing life until her last year in the school. If a nurse begins "grumbling" in her student days, she will be a capital grumbler when she is graduated. That word loyalty covers a great deal. It should be in-bred in the student nurse: stick to one another, help one another, obedience without questioning, and, in so doing, banding themselves, as nurses, together.

Unhappy will he be who lets his mind
Long dwell on troubles that we all must find.
They are but pebbles on a pleasant path
To call us to attention, not to wrath.
Walk calmly by and leave them all behind.

Loyalty to the patient, whether he be rich or poor, giving the same service, not because he is so-and-so and may make trouble, but because he is ill and needs what the nurse can give. Loyalty to the doctor, whether he is the good-looking, popular one, or whether he is Dr. Blank, who is a bit uncouth. For the nurse's own self she must not let any discrimination interfere with her service. Inwardly, she may have her favorite on a pedestal, but not outwardly.

Service comes thirdly. It is a word that means much. The nurse-in-making will be the finished product one day. An able writer has said, "Life is for growth," and it is the growing nurse who turns into the graduate at the completion of her days-in-training. Service: the nurse who has the ability to put her theory into practice, to give to the public what it requires in the nursing line, what it is able to pay for. Service: to abnegate oneself, to nurse the patient with no thought of self.

And lastly, *Education*: To work intelligently, the nurse must have acquired, at least, matriculation standing. Education comes from the Latin words *ex* and *duco*, meaning to lead forth. Education is simply a training to meet life, and there is no one who requires a better training than the nurse. Through being educated she is able to use the knowledge acquired to nurse her patient intelligently. But, first, she must have adaptibility, loyalty, and be willing to serve, otherwise her knowledge is void. The higher education she has the better should she be able to use her life in the nursing service. Think of the nurses who have the higher education, those with degrees of learning. Think of those you know individually; are they the better nurses for the degree? Normally speaking, they should be, for all education should help one to live more fully. But are they better

nurses? I can think of three that I know intimately—one in administration, two in special nursing. None of them are doing outstanding work. All three are good nurses, but no better than the nurse who has matriculated. Therefore, I say, the power to use what the student nurse gains through the three years of her training does not go to the higher educated nurse any more than to the nurse who has matriculated.

Is the public asking for the higher educated nurse? It is asking for a further training in the special branches of nursing. For instance, the nurse doing public health work, school nursing, administration work, must have training in these particular branches of nursing, but this should come after graduation. Even the private duty nurse improves with experience that has come to her after graduation. When she gets away from the hospital and has to improvise and use what is at hand in the home, it is, as it were, her post graduate training.

How can the superintendent of a school for nurses weed out the misfits in her probation class? It is a difficult task, for often the nurse who in her probation days seems a misfit, has lying dormant those essentials for a successful nurse. Will intelligence tests help? More and more frequently, intelligence tests are coming to be regarded as an important type of entrance examination, or method of selection from among a multitude of applicants. This is true in a few business and industrial concerns, in some branches of the civil service, and, most frequently, in schools and colleges of various types. But first it is necessary to decide (a) how closely success in the chosen field is related to the possession of a high degree of the quality which is believed to be determined quantitatively by the test, and (b) to what extent is the possession of a high degree of this quality, the most important factor in such success. At least, we must attempt to determine the relation between success on the test, with success in the undertaking on which one is about to embark. The highest correlations have been found between intelligent test scores and academic success, but, even here, we do not escape from the conflicting factors of environmental circumstances, personality and character differences, and the influence of attitudes, interest and desires. The question is always a complex one. In any attempt to estimate the value and desirability of using intelligence tests as a means of selecting the best individuals from among the applicants for entrance to a nurses' training school, these complexities remain and must be dealt with.

Although investigations of the correlation of intelligence test scores with training school success have been reported, little conclusive evidence has been found. It must be remembered that in schools for nurses where the completion of the high school course is a requisite for entrance, a considerable degree of selection from the point of view of intelligence has been effected already.

The Otis Group Intelligence scale was given to 128 student nurses and probationers. The Thurstone Cycle Omnibus Test was likewise given to the probationers and the senior nurses. One of the most interesting aspects of the results was the fact that the average score made by the probationers was twenty points above that made by any of the other three classes. This is especially interesting when we consider the fact that there has been no change in the entrance requirements during the past four years, and that the teachers declare that this class does not seem above the average in any way. The average scores made by the three up-

per classes correspond closely to Otis's norms for average unselected adults. The median score of the probationers which shows a deviation of twenty points above this level, seems thus to indicate that they are a more selected group from the standpoint of intelligence, in spite of the evidence given that no organised attempt was made to make a better selection, and that this seeming superiority has not been observed in their work. More widespread and continued testing of student nurses is the only way in which more light can be thrown on the question to discover whether the difference shown here is merely a chance difference between two groups of individuals, or whether it represents a general tendency. Only by repeated testing of the same individuals during their progress through the school for nurses can it be discovered whether or not this difference is significant of an actual decrease in the ability necessary for achievement on this test. It suggests that differences in intelligence, above the minimum standard, already assumed as a requisite for graduation from high school, do not form an important factor in the qualifications for success in nursing, and that individuals considerably below the general adult norm in intelligence are not only capable of passing the nurses' training course, creditably, and of becoming registered nurses, but that this is quite a usual occurrence. While it may be assumed that intelligence undoubtedly is a factor in nursing qualifications, it is one whose importance is difficult to single out and measure. An attempt to determine with any degree of accuracy the most desirable level and type of intelligence to be required as a qualification for entrance into the nursing profession will be faced with many difficulties, and may prove to be of little value.

A possible hypothesis would be that differences in intelligence taken as an isolated factor, so long as the degree of intelligence remains within normal limits, do not have as much weight in determining future success in nursing as does the possession of other traits and characteristics, qualities pertaining to the physical makeup, the personality, and the acquired attitudes, interests and desires of the individual. It is in this sense that intelligence testing may prove to be a relatively unimportant and inefficient method of selection as compared with one in which an attempt would be made to define and measure whatever other qualities may prove to be more closely related to nursing ability. The intelligence test is no more a panacea than is the surgeon's knife—it is merely an instrument to be used for a specific purpose, and with full knowledge of the conditions under which it is to be used and of the benefits to be expected as the result of its use.

QUEBEC

In an effort to raise nursing education standards in the Province of Quebec, as recommended in the Report of the Survey of Nursing Education in Canada, the pass mark for registration examinations has been raised 10% during the recent session, with an increase in the percentage of failures as follows:—One hundred and forty-three nurses wrote, and fifty-six failed to pass.

It is earnestly hoped that as time advances, the individual nurse will realise the value of nurse registration, and that she must co-operate more fully with the teaching staff of her school, so that this final "Hallmark" of distinction may be hers through merit.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section,
MARY F. CAMPBELL, 344 Gottingen Street, Halifax, N.S.

SIDELIGHTS ON SUPERVISION

By MARION NASH, Educational Director, Victorian Order of Nurses, Montreal, Que.

Perfect things do not interest me. The problem solved, the situation under control, I soon grow restive. I think that is why this job of supervising has held me for so long. There is always something new to learn, some difficulty to adjust, some better method to try out. We are still in the experimental stage, therein lies the fascination, and while I would like to see an improvement in the technique of supervision, it is my fervent hope, that we will not soon reach perfection.

Dr. Weir, in his Survey on Nursing Education, defines education as modification of conduct, and enlarges upon the fact that education is not effective unless it leads to emergence of appropriate conduct in life situations. Again Dr. W. H. Burton of Columbia University has defined supervision as an expert technical service designed to improve the efficiency of groups of workers under supervision. In other words supervision aims to help individuals to more readily modify conduct. It would appear then that, as the aim of supervision is to help the nurse, or groups of nurses, to adapt to life situations, and to grow and develop in service, the terms education and supervision are synonymous.

I think we are all agreed that on graduation the nurse's education is not complete, but if we have kept in mind during training school days that we are preparing this young woman to meet certain life situations; if we have endeavoured to teach her how to think, not what to think, then she is ready for the great adventure. Not least among the many things she should have learned is, that education is a life long process, that her training has but pointed the way, and opened the gateway to further knowledge.

If then the young nurse is at the beginning of her career, does it not seem rational to suppose that she may need help in adjusting to the new life. We do not expect the young lawyer or physician to be ready to practise directly he graduates from university. He must spend some time in law office, or hospital, as the case may be, but the young nurse, with less education, and less preparation, is practically cut adrift, to succeed or fail. In point of fact we send forth this young woman to do something for which we have given her very little preparation. The nurse will, in the majority of cases, assume responsibility for the sick patient in the home, a difficult task requiring the exercise of many skills, and up to the present we have left her entirely alone, to carve out her own career. Our method surely indicates that we think graduation is the end result to be achieved. Do we not give the young graduate ground for supposing that her education is finished rather than just beginning on graduation day?

Nurses must face facts. Since we are all more or less imperfect,

(Read at the Public Health Nursing Section, Canadian Nurses Association General Meeting, June 24th, 1932.)

whenever groups of people are collected for the purpose of carrying out some specific piece of work there must be someone to co-ordinate and direct, someone to advise and inspect. This holds good in the business world and I think experience has proven that the same principle is sound when applied in the world of nursing. Modern Public Health Nursing has from its inception recognised the necessity for supervision, but the supervisor in public health nursing, as in teaching, confined herself for many years, to one phase of supervision, and that, the least important part, namely inspection. This place of supervision fell into disrepute because the supervisor very frequently thought of supervision, merely as an opportunity for criticism. Supervision is something more than this, and yet inspection is a legitimate phase of supervision.

The supervisor must survey her field, she must know the weakness and the strength of the material with which she has to work. If nursing care to the patient is included in the programme, that nursing care must be of the first quality, because, whether we will or no, the patient criticises the nurse, and is not likely to put much confidence in instruction given by a nurse who is not skilful in giving the treatment that is important to his or her recovery. The nurse's approach to the patient and family, her skill in seizing her opportunity to teach, her skill in presenting her material, her knowledge of her subject, her ability to adapt to home situations are all important factors in the making of a successful visit. The new nurse may therefore need considerable help in adjusting to new conditions and in perfecting new skills.

Most Public Health Nursing Organisations, aim to anticipate the needs of the new nurse by giving her the opportunity to observe the senior in the field, by class room instruction and by conferences, but the supervisor must visit with the nurse in order that she may see for herself the type of work for which this nurse is best suited, and in order that she may help her over difficulties. I would like to emphasize that last phrase —the supervisor is there to help the nurse with her difficulties, not for the purpose of criticising. If the supervisor would be successful she must think with the young girl of twenty, and see things through her eyes. She must remember her own mistakes as a young graduate, and she must remember why she made those mistakes. She must keep in mind that being human, she is still liable to err. She must tread cautiously, remembering that she has the shaping of a new career, and that in these first visits she is helping to build attitudes. It is her privilege to develop initiative and executive ability, and to make or mar a precious thing. This is no task to be lightly undertaken; if however she keeps in mind that praise is more potent than blame, if she passes over the trivial errors and praises the task well done, if she leads the nurse to suggest for herself the tasks that might have been more skilfully performed, she will find that far from dreading another visit of the supervisor, the nurse will look forward to that visit as something to be hoped for and appreciated. In other words, by her sympathetic understanding of the difficulties, and tactful advice she should endeavour to instil in the nurse healthy attitudes toward supervision so that the nurse will look upon her as a friend who is ever ready to listen and advise.

The home visit has then a two-fold purpose: (1) Observation or Inspection in order to collect data, and (2) Advice that will help to improve the quality of the work.

There is still a third important phase of Supervision which for want of a better term we might call

Guidance. The nurse must be stimulated to read and study. There are many things she needs to know that are not taught in the training school. Her reading must be directed, she must be stimulated to want to hear good speakers, to learn to criticize their method of approach and their method of assembling material. A library is a necessity in any Public Health Organisation; Nursing and Medical Journals should be taken, and it is part of the supervisors work to find time to read the magazines, and draw the attention of the staff to the more important articles. In order to encourage the nurses to read, we keep in our office a magazine file. A committee, appointed each month from the staff, goes over the current magazines, notes the interesting or helpful articles, lists them under headings and they are then typed for the file by the clerk. This encourages reading and enables us to have on hand valuable material, easily located for reference. Attendance at meetings always calls for a few minutes' discussion on return to the office. In this way the experience of the supervisor, or member of the staff privileged to attend, is shared by the group.

We have discussed supervision under three headings: Observation, or Inspection, Advice and Guidance, but there is a larger and more important function that is sometimes overlooked. By visiting in the home, by supervising the records, by noting the reaction of the staff to doctors, social agencies, to one another, by noting how problems, social or medical, are handled, the supervisor obtains a good idea of the strength or weakness of her particular staff. The next step must be to devise an educational plan that will meet these definite needs. Nurses whose education does not meet accepted standards might be encouraged to attend night school. Classes in Public Speaking might meet the needs of those who quail at the sound of their own voices; in a university centre, some nurses may take one or more of the Public Health or Cultural Courses, but for many reasons these arrangements will not serve the whole group. How, then, are we going to plan our educational programme in such a way that all the staff may participate? The Victorian Order of Nurses' staff of Montreal meet the situation in the following way:

In this office the weekly district conference is used for educational purposes. The staff nurses control the meeting, re-electing officers each fall. The chairman calls for suggestions from the staff on the winter's programme. An executive meeting follows, and these suggestions are considered. When the programme is more or less organised the supervisor is invited to a meeting. She goes to this meeting knowing the needs of her staff, and if she is sufficiently skilful, the programme that is finally accepted will meet these requirements, and at the same time will have developed out of the discussion initiated by the nurses, not by the supervisor. Keeping in mind our objective, to develop the latent abilities of all the nurses, and particularly the less studious or those lacking in initiative, every nurse is encouraged to take part in the programme. In this way the timid retiring type are induced to take leading parts as well as those who are more capable.

Last winter the project was to improve our ante-natal teaching and especially the nutrition teaching. We wanted to improve these visits on several counts—

(1) Knowledge of our subject.

(2) Method of assembling material.

(3) Method of approach to the individual patient.

(4) Method of presentation.

An imaginary, young primipara

of fair education, and moderate income, was chosen, and for this imaginary patient we planned several ante-natal visits. These visits were presented in our District Office. No two visits were made by the same nurse or pair of nurses, and each visit grew naturally out of the preceding one. When we finished in June we had made to this patient seven visits and we had not yet begun to exhaust our subject. We purposely chose a patient who was normal, and a home free from social difficulties to demonstrate how many opportunities might arise for teaching the better educated patient if the nurse was prepared, and alert.

A project of this kind keeps every one interested, each one listens attentively because she is on the lookout for suggestions, she learns to listen critically and yet tolerantly, she learns to be sure of her facts, she learns how to present these facts in a convincing manner, how to hold interest, and finally she learns how to speak in public. In our office we never know when we will have visitors; the nurses are entirely responsible for the success or failure of the conference and naturally they take more interest in its success than if the responsibility rested upon the supervisor.

To summarize, the supervisor should not be content with helping the individual nurse but should, after surveying her field, plan an educational programme for the group that will strengthen the weak, and stimulate the strong. In order that this plan may be effective, considerable responsibility must be thrust upon the staff. They must realise that the responsibility for the success or failure of the project rests upon them. The project should be chosen as the result of the nurses' deliberations.

As the purpose of the project is to help the nurse to improve her work, the supervisor should be prepared to suggest reference reading, and to confer with the nurse on her paper before it is presented in public. Discussion should follow the presentation of each paper, good points should be brought out, weak points discussed. The supervisor should take as little part in the discussion as possible, but at first it will be necessary for her to lead in the discussion and possibly to summarize. The nurse should and does experience a great deal of satisfaction as the result of her achievement.

Heretofore, we have thought almost entirely in terms of the supervisory visit in the home, and have given little consideration to the larger purpose of supervision. While the supervisory visit with the individual nurse is important, I think we should look upon it more or less as our opportunity to study the needs of our particular staff, and so contributary to the more important side of supervision —namely, the developing of an educational plan that will draw out the best that is in our nurses, and allow for the exercise of initiative and executive ability. If our nurses are encouraged to think for themselves and to act as the result of critical thinking, we will not have much cause to worry over the future.

SUPPLY AND DEMAND OF PUBLIC HEALTH NURSES

By ESTHER M. BEITH, Director, Child Welfare Association, Montreal, Que.

Walter Lippman, Editor of the *New York Herald-Tribune,* in his address to the National Conference of Social Work held in Philadelphia last month (May, 1932), when discussing present economic conditions, made the following statement: "In the Western World at least we have solved the problem of scarcity. Our problem now is the management of plenty."

In attempting to review the question of Supply and Demand in reference to Public Health Nurses as dealt with by Dr. Weir in the Report of the Survey of Nursing Education, we are in spite of Dr. Weir's warning, tempted to use the interpretation of our individual opinions and experiences, rather than those of the Survey and the body of nursing facts as compiled under the direction of the Joint Study Committee. To this Committee every nurse and potential nurse in Canada owes a debt of gratitude.

Within the last few days, I have had the privilege of reading the excellent paper given to the Nursing Section of the Canadian Public Health Association by Dr. Mitchell, of the Mental Hygiene Institute of Montreal. Dr. Mitchell emphasizes the Survey Report's often reiterated statement for the lack of preparation public health nurses have for their teaching function, the function on which their entity depends. Judging by Dr. Mitchell's standard, I am tempted to assume that the supply of public health nurses in Canada is practically zero after taking part in the unlimited number of economy meetings held by the Public Health and Social Organisations in Montreal and having a knowledge of applications on file in our own Organisation, I could almost question the existence of a demand. Therefore if this discussion were to be limited to my own interpretation and opinion of its title, the reasonable thing to do, would be to sit down and end this paper now.

(Read at the Public Health Nursing Section, Canadian Nurses Association General Meeting, June 24, 1932.)

Supply and Demand of Public Health Nurses

However, if you are to be denied this reward of my own rather pessimistic view we can turn to the statement of facts in the Survey Report. In 1929-1930 there were 1,521 nurses actively engaged in public health nursing in Canada. A number, which Dr. Weir states, was 20% below the demand at that time for the whole of the Dominion, and 40% below the demand in the Maritime Provinces. I think we can state that these 1,521 public health nurses, while realising the truth of the Report's and Dr. Mitchell's challenge as to their lack, with some few exceptions, of an adequate knowledge of teaching methods and Mental Hygiene, have created a demand which can absorb any qualified public health nurse existing in Canada today. This does not include every nurse who wishes to do public health nursing. Our problem still is the management of scarcity.

If we accept, as we should, Dr. Weir's interpretation of the present public health nursing situation, there should be a position in Canada today for 1825.2 public health nurses. Recently I secured information from the East Harlem Nursing and Health Service as to the number of families that they alloted to each nurse in their generalised Public Health Nursing

scheme. This was from forty to forty-five families — approximately 250 individuals and this is a congested urban area. Many of our Victorian Order of Nurses are giving this type of service but I fear not on the same numerical basis.

If we could apply East Harlem standards of service to Canada, even without any discrimination in favour of our rural areas, we might interpret our public health nursing needs in a somewhat more generous manner than that of the Survey Report.

One of our foremost public health authorities places the percentage of our population outside the scope of such nursing service as 5%. The figures in the Report are based on a population of 10,000,000. Taking this figure with East Harlem standards our present need for public health nurses would be 34,000. An Utopian idea, you would gasp, and yet at the time of the Survey there were, including students in training, 30,510 nurses in Canada—one for every 327 individuals. Our problem now seems the management of plenty.

In the event of the socialisation of our medical and nursing service, which some of us think, with the Survey Report, is not so far distant, would the function of any large number of nurses be absolutely outside the public health nursing field. Hospitals and institutions are even now recognising the value of the socialised training of public health for many of their positions. However, from 1,825 to 34,000 is a long step. We are quite aware that the need on such a basis is greater than the demand.

We might go still farther in attempting to disagree with the Survey Report's estimate of the demand or rather to advance it five years. I think most public health organisations feel that they might double their present nursing staff at once, if they were not limited by lack of available funds. This again would be the fallacy of individual opinion against compiled facts.

We turn to the economist, John Stuart Mill, who tells us that demand is not limited by means to purchase. It is limited by desire to purchase. It is only in time of crisis, due to lack of confidence, that if sufficient desire is present it does not consume the supply. Some of us who would have preferred to motor to Saint John feel that this is hard to believe! The supply of motor cars seems more than adequate, and we think we have the desire. Nevertheless, we came by train. We admit the crisis!

The economic crisis, methods of distribution and various other factors, are responsible for the greater part of the unemployment of our nurses today, but we still agree with the Report, though we know unlimited instances of people wanting nursing service and going without because they are unable to pay, that the production of nurses is greater than the desire for nursing service. Certainly in order to assimilate 34,000, the present public health nurse will have to create a desire for Health Education that it is more urgent than it is today.

Our problem in Health Education, especially in the nutrition field, is giving us excellent training in attempting to create a desire for things that people do not seem to want. Stew rather than roast beef and cod fish rather than salmon. It should be possible to persuade them to acquire their Health Education and Nursing Service from a qualified public health teacher rather than from their next door neighbours. In one instance we are endeavouring to create a desire for a cheaper article, in the other for a somewhat more expensive one, if judged by an immediate monetary value. If one may again use a personal experience, a desire

to spend seems easier to acquire than a desire to save.

When we speak of the supply and demand of public health nurses, we should ask ourselves: What are public health nurses and why should the community demand their services? The Survey Report tells us that an active public health nurse is one of 1,521 women whose median age is 37.4, who has spent 3.3 years in high school and whose median nursing experience is 8.8 years. Fifteen per cent have had normal school training, 93% have spent 36 months in a hospital training school; 7%, 30 months, and 58% have spent 9 months in taking special courses. The purpose for which the demand for this type of nurse's service exists, is the education of the community in healthy living, either through a bedside nursing programme or by straight health supervision and teaching methods.

Health as applied to living is too complex a problem for discussion here, even were I competent to discuss it. It is sufficient to say it evolves a physical, mental and social health programme, the interreactions of which are so involved that it is impossible to separate them. If we consider a health teacher in this broadest aspect, I think we will all admit the nonexistence of an adequate supply.

At least 15 years ago, the public health nurse entered the field with her attention directed toward physical health problems. Her preparation was that given to her in her training school, plus leadership from certain physicians and nurses who had vision to see beyond a curative programme, back to prevention of disease and then to positive health. Her success—for she has been successful if our means of judging the results of her work are accurate, and in general I do not think any have dared question them—was due rather to her personality, her prestige as a nurse, plus factual material. She superimposed her ideas on individuals and persuaded or dragooned them into certain health measures, but this was not health education. She soon found that she was confronted with a task for which she was educationally totally unfit, as the Survey Report might suggest — she was born but not made. In the last fifteen years much has been done to improve this situation. Nevertheless the supply of nurses qualifying themselves by university post graduate course has been quite inadequate to meet the demand for their service. This year it is true many organisations have been forced to refuse qualified applicants not because they are not required, but due to the fact that during times of scarcity Public Health organisations employed unqualified nurses. These nurses, having filled the breach in prosperous times cannot, in fairness, be turned back into the present overstocked private duty or institutional fields.

If qualified public health nurses are unemployed it is due to a problem of management and distribution. The demand still exists and will exist increasingly if, as the Survey Report states, vigorous and enlightened leadership is available.

When we speak today of a qualified public health nurse, we refer to the nurse whose educational attainments are such that she has been admitted to, and received a diploma from, a university post graduate nursing school. Such schools have recognised her need for training in teaching methods, in mental hygiene and sociology—nine months is a short period. We agree with most of our nursing education leaders that if the public health nurse is to compete educationally in the field, with certain allied professions, she must qualify for and be given a degree.

Since coming to the Convention,

listening to Professor Fraser and hearing other discussions by nursing educationists, I would like to qualify the above statement. I am not a leader in nursing education and my opinion is coloured somewhat by personal experience. For the last two years in Montreal we have established a Health Service for twenty-six of the thirty-two agencies in Financial Federation. These agencies are staffed by social workers, the majority of which are demanding of their staff a Bachelor or Master of Arts degree, plus two years in a recognised school of social work. The physician, the public health nurse, the nutritionist and the social worker meet together in a joint health (I speak of health in the broadest aspect) programme for the family. We feel that the public health nurse's contribution to health as a whole is at least of equal importance to that of allied groups. I am not particularly interested in degrees as such, merely pleading for an educational standard.

Those of us who are working in the field today, even without Dr. Mitchell's and the Survey Report's warning, are thinking seriously as we venture into adult group education, into mental hygiene, into social problems from which no public health nurse can divorce herself—are we going to measure up to the demand which has been created? The health teacher of the future is confronted with the task of at least participating in the mental and social health field as well as the physical, and the serious idea for us to think over is the fact that much of the demand of the future depends on how the present supply functions.

BOOK REVIEW

SCHOOL NURSING: A Contribution to Health Education by Mary Ella Chayer, Instructor in the Nursing Education Department, Teachers College, Columbia University. Published by G. P. Putnam's Sons, Knickerbocker Press, New York City, 1931. Pages 285. Price $2.50.

The strength of this book, and its distinctive contribution, lies not so much in the outlining of methods and procedures used by the public health nurse in school health work, but rather in the portrayal of a sound philosophy concerning school nursing and its relation to the school child. With penetration and discernment, the author thinks beyond the daily practices of the school nurse to a discussion of educational principles governing those procedures, and beyond that again to a sound philosophy of such practice. Nor is that all. In a study of the relation of the nurse to the school child her approach is a scientific one. From a wide range of source material she brings to bear upon the subject the most recent findings of scientific research. The author argues throughout for the integration of all services focussing upon child health and for a point of view which considers the child not only in terms of school, home and community relationships, but of life itself.

The book comprises twelve chapters in all with a comprehensive bibliography. Several appropriate illustrations are included. The first chapter deals with the historical background of the subject, tracing something of the evolution of public health nursing and its emergence from visiting nursing. The student of history could have hoped for more pages given to that aspect of the subject. The chapter on Principles of Education as Applied to the School Nurse includes the topics: Purposes of Education, Criteria for Evaluating Activities and the Changing Concept of Health. Of equal value is a chapter on the Factors of a Healthful School Environment. A third one, The Health Inventory, gives consideration to the Health Examination, to Dental Hygiene and Nutrition and to Trends in Weighing and Measuring. A chapter is devoted to each of the following: Nursing in Secondary Schools; Parent Education; Relationships within and without the School.

All told the work is a timely addition to the documentation on this subject. Moreover, it is the result of a wide experience in sound, progressive practice and is commended to the attention of those engaged in this branch of public health nursing.

F. H. M. E.

International Council of Nurses

Nurses in Canada who are planning on attending the Congress, International Council of Nurses, July 10-15, 1933, in Paris and Brussels will be interested to learn that arrangements have been made by the Canadian Nurses Association through Thos. Cook & Son, Travel Agency, for a sailing to be made on the Empress of Britain on July 1st.

The complete individual fare for what may be termed the official tour from Montreal back to Montreal will be $280.00. The return will be made on the Duchess of York, sailing from Liverpool on July 21st. Arrangements can be made for those who wish to leave Canada before July 1st as well as for those who may want to remain abroad for sometime following the Congress. This, of course, will mean additional expenditure to the above quoted rate.

Following the close of the Congress this tour will include an excursion to Waterloo from Brussels on July 16th. The following day the party will travel to London via Ostend and Dover. July 18th to 20th will be spent in London for sightseeing, also an excursion to Windsor Castle, etc. Departure by rail for Liverpool is scheduled for Friday, July 21st, from where the party will sail for Canada on the Duchess of York.

The inclusive fare is based on a party of at least 25 members. From the responses coming in to National Office since copies of the preliminary announcements were circulated, it is estimated there will be no difficulty in the party reaching the minimum required.

THE FARE INCLUDES:—

Steamship Accommodation: Stateroom berths on the Trans-Atlantic steamers, consisting of Tourist Class accommodation specially reserved for the party, and first-class on Cross-Channel steamer.

Rail Travel: Second-class on the Continent and third-class in Great Britain, which corresponds to Continental second-class.

Hotel accommodation at good comfortable establishments, particularly well chosen for the convenience to points of sightseeing interest and for the quality of accommodation provided. This includes room and breakfast in Paris and Brussels, (usual Continental breakfast, consisting of rolls and coffee), throughout the Congress period. This is in accordance with the special request made by the Congress Committee, as a number of official luncheons and dinners will take place which no doubt most of the nurses will want to attend, and furthermore, the daily sessions of the Congress will be all-day affairs, resulting in inconvenience to the nurses if they have to return to their own hotels for meals. All meals will be provided en route between Cherbourg and Paris, Paris and Brussels and Brussels and London. In England, breakfast will consist of a full meal, with meat or eggs and table d'hôte lunches and dinner.

Sightseeing: An excellent programme of sightseeing is included. Visits will be make by sightseeing automobile to the principal places of historic, literary and scenic interest, and the leading museums and galleries.

A Tour Manager will be provided to travel with the tour from arrival at Cherbourg on July 6th to embarkation for Canada at Liverpool on July 21st and will take charge of the pre-arranged sightseeing and excursions, the travel arrangements of the tour, and will generally assist the members of the party in making any private arrangements they may wish.

Fees or tips to hotel servants, porters, chauffeurs, etc., while accompanied by the Tour Manager, also admission to public buildings, museums, etc., are included.

Transfers of passengers' baggage between railroad stations and hotels, or piers, are included.

Baggage: Members should take as small an amount of baggage as possible, a standard suit-case or any ordinary suit-case will be carried free of cost. Members may take an over-night handbag containing the necessities of travel for use on trains and local steamers, which must be carried and transferred, by and remain under to the control of the owner at all times.

Taxes on travel and hotel accommodation as at present imposed by the governments of the countries visited, are included.

THE FARE DOES NOT INCLUDE:—

Expenses of passports and visas, laundry, wines, mineral waters, after-dinner coffee or food not on the regular menu, the expenses of carriages, automobiles, guides or sightseeing not specified in the itinerary, or ordered by the Tour Manager, or baggage insurance, which is strongly recommended.

An earlier sailing can be made from Canada, on S.S. Duchess of Richmond, from Montreal on June 16th arriving in Glasgow, June 23rd. The following day the party will travel to Edinburgh by way of the Trossachs, by rail, coach and steamer. After two days in Edinburgh, by rail to to Keswick via Carlisle, then by motor coach to Ambleside for one day. Travel to Windermere and Chester will be by coach on June 29th The party will have a morning in Chester, then on to London, arriving there the afternoon of June 30th.

Canadians could not wish for a more enjoyable July 1st week-end than one in London which in this itinerary would extend to Tuesday evening, July 4th. Travel to Paris will be made via Folkestone and Boulogne on July 5th—this arrangement allows for four days in Paris previous to the opening of the Congress on Monday July 10th. Those wishing to return at once to Canada can arrange to sail from Antwerp on Saturday, July 15th.

As the Canadian Nurses Association has undertaken to co-operate with Thos. Cook & Son in transportation arrangements for nurses from Canada it will be advisable for members of the Canadian Nurses Association to make their reservation for accommodation through the organisation.

Institute of Public Health
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News Notes

Contributors to this Section are reminded that the address of the Journal is now 401 Crescent Building, Montreal, Que. Copy for this Section should reach the Editor not later than the twelfth of each month for ensuing issue.

BRITISH COLUMBIA

Results of Examination for Registered Nurse's Certificate

An examination for Title and Certificate of Registered Nurse was held recently throughout the province with the following results:

133 wrote the examinations.
116 passed.
6 passed with supplementals to write.
4 passed Supplemental Examinations.

Standing in order of merit:

First Class—80% and over;

Misses: F. L. Ferguson, Royal Jubilee Hospital, Victoria.
I. M. Cope, Vancouver General Hospital.
B. S. Moody, Vancouver General Hospital.
W. Bond, Vancouver General Hospital.
M. A. C. P. Clark, Port Simpson General Hospital.
H. M. Keiver, Vancouver General Hospital.
M. A. Edwards, Vancouver General Hospital.

Second Class—65% to 80%:

Misses W. M. Gowen, L. B. Hunter, V. M. Porter, R. J. Orr, M. J. MacDonald, (E. K. Simpson, E. D. L. Luesing, S. E. Freeman and A. C. MacKenzie—equal), E. A. A. Hiles, (M. R. Smith and R. B. MacLellan—equal), M. M. Keary, E. L. Cudmore, N. C. Bennett, F. C. Jostad, I. N. McQuarrie, M. B. Butchart, M. Robertson, H. A. Becker, M. M. Downey, (I. McLachlan, K. R. Begg, M. A. Baynes and J. I. Campbell—equal), J. M. Hunter, (M. C. Miles and G. McFadyen—equal), H. L. Holliday, (M. L. Smythe, L. M. Chase and M. E. Hammond—equal), (M. Burkhart and M. S. Hartley—equal), N. V. Lee, (K. Ringshaw and S. N. Keillar—equal), (Mrs. F. A. Thompson and M. Elliott—equal), (M. J. Murdoch and J. F. Home—equal), (W. M. Chapman and A. M. Laidlaw—equal), (M. R. Duff, C. J. Tremeer and N. J. Richardson—equal), M. E. L. Fraser, (M. A. Calhoun and G. M. Jones—equal), A.D. R. Grant, (A. L. Dickinson, E. K. Stady, D. E. Tate and E. S. Lemm—equal), J. E. Hill, (T. M. Hopkins and C. M. Laidlaw—equal), C. M. Todd, E. J. Ryan, M. E. Moffat, A. M. Sylvester, (M. K. Earle and V. E. Taylor—equal), E. C. Duffield, (G. E. Macrae and M. P. R. Munro—equal), C. E. Cornell, M. L. Parson, (J. W. L. Smith, G. M. Forrest and M. M. Allaire—equal), (M. M. Ferguson and E. M. Rathie—equal), M. E. Wilson and H. B. M. Holmes—equal), E. L. Buckley and S. Lebedovick—equal), A. L. Lancaster, G. Dawson, F. I. Moore, (I. M. Dale and O. M. Huggins—equal), E. A. Alexander and E. B. Schroeder—equal).

Passed—60% to 65%:

Misses (O. M. Haggman and G. M. Jones—equal), I. C. Pike, H. W. Stevenson, C. G. Nucich, T. D. Green, A. A. Swanlund, I. I. Cumming, P. L. Madill, (J. I. Gray and V. Waram—equal), E. M. McDiarmid, (M. P. Dobbie and D. E. Stewart—equal), N. V. Waind, (D. R. Corble, M. P. Jones and P. A. Murphy—equal), J. I. Stewart, B. R. Merrill, (V. deBlaquière, I. Craig, A. M. Elliot, E. F. Lord and I. A. McGarrigle—equal).

Passed Supplemental Examination:

Misses H. K. Beckett, L. I. Buckmaster, N. E. Foster, I. Morgan.

Passed, with Supplemental to write:

Misses F. L. Fletcher, M. Gilbert, M. I. Mackenzie, Mrs. B. L. Mackie, W. M. Robillard, L. M. Somerville.

Graduate Nurses Association, Victoria: The V.G.N.A. held a regular monthly meeting at the Nurses' Home, Royal Jubilee Hospital, on November 5, 1932. The meeting was well attended, in spite of the inclemency of the weather and an epidemic of colds. After the routine business of the month, the Private Duty Section took charge of the programme. Chapter Five of the Report on the Survey of Nursing Education in Canada was studied. The study was synoptical. Several of the members had prepared papers giving a synopsis of the principals involved in each paragraph, in this way giving a general review of the chapter. A round table discussion on the chapter was led by Miss L. Mitchell, Director of Nursing, Royal Jubilee Hospital. It is the intention of the Association to study sections of the Survey Report in this manner, at regular meetings throughout the winter.

Jubilee Hospital, Victoria: The regular business meeting of the Alumnæ Association was held in the Nurses' Home, September 19. Owing to the resignation of the president, Miss Elise Oliver who is to be married in the near future, Miss Jean Moore was appointed to that office. The programme for the winter was discussed, plans for which were left to the Entertainment Committee. A special effort is to be made along social lines, thus endeavouring to interest younger members of the Association in their Alumnæ.

MANITOBA

BRANDON: The regular meeting of Brandon Graduate Nurses Association was held on November 1, 1932, at the Nurses' Home, General Hospital. Much important business was discussed and as a result the new schedule of fees was arranged for private duty nursing. Fees for private duty will be $3.00 for 12-hour duty and $3.50 for 24-hour duty. A fee of fifty cents will be charged for hourly visits and where the visit is prolonged the fees will be adjusted by the nurse herself. The registration fees for private duty nurses were reduced to $2.00. During the evening Miss Jean Houston, President, Manitoba Association of Registered Nurses, gave an interesting report of the Biennial Meeting of the Canadian Nurses Association. The report dealt with various sections of the Report on the Survey of Nursing Education in Canada. At the close of the meeting refreshments were served by the General Hospital Group.

CHILDREN'S HOSPITAL, WINNIPEG: The first general meeting of the Children's Hospital of Winnipeg Alumnæ Association was held in the Nurses' Residence, on October 21, 1932. The election of officers was as follows: President, Miss Catherine Day; 1st Vice-President, Miss Edith Jarrett; Secretary, Miss Elsie Fraser; Treasurer, Miss M. Hughes; Committees: Entertainment, Mrs. George Wilson; Sick Visiting: Miss M. Atkinson and Miss H. Clarke; Refreshments: Miss A McAully. A hearty vote of thanks was tendered the retiring President Mrs. George Wilson, for her untiring efforts during the past years. Plans were discussed for the activities during the coming year, and various means by which funds might be raised. A social hour followed.

ONTARIO

APPOINTMENTS

PROVINCIAL DEPARTMENT OF HEALTH: Miss Gladys Motley, graduate of the Public Health Nursing Course, University of Toronto, 1932, commenced her duties in Haileybury in October. She is replacing Miss Florence Farr, who resigned to take the Public Health Nursing Course at the University of Western Ontario, London. Miss May E. Hamilton has been appointed to the school nursing staff of Port Arthur, beginning her duties at the opening of the school term. Miss Hamilton, a resident of Port Arthur, is a graduate of the Public Health Nursing Course, University of Toronto, 1932. Miss Christine M. McLaren, graduate 1931, from Course Two, University of Toronto, has succeeded Miss Hazel I. Atkinson as public health nurse in Perth. Miss Petronilla Schurter has been reappointed school nurse in the Separate Schools, London. Miss Maud C. Weaver is engaged for temporary service as public health nurse in Orangeville. Miss Weaver was in Chapleau from January to June, the service there being discontinued for financial reasons. Miss Hazel I. Atkinson has been appointed public health nurse at Kirkland Lake, replacing Miss Campbell, who resigned to be married. Miss Maud Campion, public health nurse, Department of Health, Brantford, has resigned her position. Her marriage took place October 29th. Mrs. Margaret Norton, graduate of Public Health Nursing Course, University of Toronto, 1932, succeeds Miss Campion. Miss Edna Squires, Provincial Public Health Nursing staff, is assisting the Wellington County Health Association to carry out a Tuberculosis Survey.

DISTRICT 1

Members of R.N.A.O. District No. 1, held a very interesting and instructive meeting in the Nurses' Home of St. Joseph's Hospital, London, on September 17, with Miss P. Campbell, Chatham, President, in the chair. This meeting followed a short refresher course in "Maternal Care" at the Public Health Institute, London, under the direction of Miss Cryderman of the Victorian Order of Nurses Staff in Ottawa, and Miss Marjorie Bell, Director of Visiting Housekeepers' Association, Toronto. Splendid addresses by the Most Rev. J. T. Kidd and Right Rev. C. A. Seager, Bishop of Huron, added much to the meeting. A report of the Biennial Meeting of the Canadian Nurses Association in Saint John, was given by Miss Agnes Mallock, London. Miss Mary Millman, President of the Registered Nurses' Association of Ontario, as guest speaker, impressed the value of membership in R.N.A.O. Miss Millman gave six reasons:

1. Because of service rendered the public through a study of Community problems an attempt is made to keep each nurse in step with her profession.

2. Because of the protection offered the individual nurse through group effort. Registration in Ontario could not have been accomplished without a co-operative and organised effort on the part of the Nursing profession.

3. Because of group development made possible through affiliation with Nursing bodies, — national and international — and through opportunities afforded for group conferences and educational projects.

4. Because the nurse who withholds membership is accepting benefits derived from an organisation in the support of which she has not shared.

5. Because the Provincial Association needs the help as well as the fee of the individual nurse.

6. Because it is only through membership in a provincial association that a nurse may become a member of the Canadian Nurses' Association and the International Council Council of Nurses.

Following Miss Millman's address a very instructive lecture was given by Dr. G. K. Wharton, London, on "The Medical Patient." The nurses of District No. 1 are concentrating

on Group Effort for the purpose of raising their 1932 quota to the Permanent Education Fund. Miss Ella Moffatt, Royal Victoria Hospital, Montreal, and recent night superintendent of the Ross Pavilion, R.V.H., has accepted the position of assistant superintendent of the Public General Hospital, Chatham. Miss Grace McKerracher, resigned her position as public health nurse of the Public General Hospital, Chatham, on September 15, 1932, and is succedded by Miss Jean Coatsworth, graduate of the P.G.H. Chatham.

District 2

Brantford: Miss L. Gillespie and Miss D. Arnold of the staff of the Brantford General Hospital, attended the Staff Nurses Refresher Course at the University of Toronto, November 7-12, 1932.

Guelph: Miss Agnes Campbell attended the Ontario Hospital Association Convention held in Toronto, October 26-28. Miss Kenny is again helping the Red Cross Society with lectures in Practical Nursing held each week at the Y.W.C.A. Miss A Campbell and Miss Groenewald motored to Chatham recently and spent a short time with Miss Priscilla Campbell, at the Chatham Public General Hospital. Her friends are pleased that Miss Zeigler is much improved after having had a very serious illness.

District 4

The regular quarterly meeting of District No. 4, of the R.N.A.O. was held on October 15, 1932, in the Y.W.C.A. in St. Catharines, the Chairman, Miss A Wright, of St. Catharines presiding. A report of Biennial Meeting of the Canadian Nurses Association, was given by Miss Margaret Buchanan, of Hamilton. Miss Jean Gunn, Superintendent of Nursing, Toronto General Hospital, spoke on "What are We Doing With the Survey?" Miss Gunn stressed that each nurse must do her part in helping to realise the recommendations brought forth in the Survey Report, otherwise very little could be accomplished.

District 5

Toronto—Instructor's Section of the Centralised Lecture Course: A meeting of the Instructors' Section of the Centralised Lecture Committee for Student Nurses was held on November 3rd at the Nurses' Residence, Hospital for Incurables, Toronto, 20 members being present. Miss Nora Nagel, of the Hospital Instructors' and Administrators' Course, Department of Nursing, University of Toronto was the guest speaker. Her subject, "Self Examination in Ways of Teaching" was most interesting and instructive. Following the address, various members brought forward problems for discussion. Miss Nagel suggested as a project, that a study group be formed for the purpose of contributing towards the History of Nursing in Canada. Miss M. Dulmage was appointed convener of a committee to study various eras of nursing in Canada. It was recommended that a comparison of the various text-books on Anatomy be made and an understanding as to what is to be considered essential information to be taught. It was decided to have a meeting of those particularly interested in the teaching of Anatomy and Physiology before the next general meeting. At the close of the business meeting, Miss Cook, Superintendent, was hostess to the group at a social hour.

Community Health Association of Greater Toronto: The annual meeting of the Community Health Association of Greater Toronto was held in Osler Hall, Academy of Medicine, October 31, 1932, the President, Miss Ruby E. Hamilton, in the chair. The reports indicated a healthy, growing organisation with 110 paid-up members. About fifty members had enrolled in the courses in Parent Education arranged by the Pre-School Committee. The Association had the privilege of hearing outstanding speakers during the year, namely, Miss Mabel Cartwright, Dean of St. Hilda's College, Trinity College, Toronto; Dean Trivett, of Holy Trinity Cathedral, Shanghai, China; Dr. Horace Speakman, Director of the Ontario Research Foundation, and Mrs. S. Harriet Mitchell, Director of Parent Education, Mental Hygiene Institute, Montreal. Officers for the coming year were elected as follows: President, Mrs. W. George Hanna; First Vice-President, Miss Helen Hefferman; Second Vice-President, Miss Mildred Mann; Secretary, Miss Elda Rowan; Treasurer, Miss M. Gordon Lovell; Councillors, Misses Lillian Barley, Laura Gamble, Ruby Hamilton, Edna Moore, E. Mildred Sellery and Muriel Winter. The speaker of the evening, Professor G. R. Jackson, Supervisor of the Study Course in Commerce and Finance, University of Toronto, spoke on "The Causes of the Present Depression," chief of which are war debts, high tariffs, and foolish investments. To the last-named cause even the small investor had contributed. A pleasant social time brought the meeting to a close.

Hospital for Sick Children, Toronto: Miss Alice Vernon and Miss Stella Hodge, 1926, have returned to Toronto after spending some weeks abroad. Miss Beatrice Shuttleworth is now on the staff of the Out Patients' Department. Miss Grace Woodall, 1930, has gone to Timmins and is doing private duty nursing there. Dr. and Mrs. D. T. Kendrick (Irene Newcombe, 1928,) have moved to Regina, Dr. Kendrick being in charge of the trachoma cases for the Province of Saskatchewan. Miss Laura Rowntree, 1930, who spent some weeks touring in Western Canada, has resumed her duties in the X-ray Department. Miss Marie Grafton, 1928, has returned home after three months at the Coast and in California. Miss Margaret Tanton, 1928, spent her holidays in Southern California. Miss Kathleen Panton, former Superintendent of Nurses, H.S.C. is spending the winter with her brother Dr. Panton, in Vancouver. Miss Doris Bews, 1928, is visiting friends at the Coast. Miss Margaret McInnis, 1928, who is in charge of Ward E at Toronto General Hospital, took a short trip

Institute of Public Health
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University of Western Ontario
LONDON

abroad this summer. Dr. and Mrs. Jack Lind (Elsie Hinds, 1929) are spending the winter in England, before going on to resume their new duties in China., where Dr. Lind will be on the staff of one of the missionary hospitals under the United Church of Canada. Miss Reba Simpson who was awarded the Alumnæ Scholarship this year is attending the University of Toronto and taking the Public Health Course. Miss Jean Morrison, 1927, is now on the staff of the Preventorium Hospital in Toronto. The Association trusts that Miss Irene Wilson, 1928, is recovering after her accident and that Miss Susan Welsh, 1928, is making a satisfactory recovery following her serious illness. The sincere wishes of the Association for a speedy recovery are extended to Miss Gertrude Evans, 1927, now of the Vancouver General Hospital.

TORONTO WESTERN HOSPITAL: Activities for fall and following months with the Alumnæ Association have commenced. Contributions to the programme consist of Reports from the C.N.A. Biennial Meeting held in Saint John, N.B., and a talk an "Hypertension" by W. W. Priddle, B.A., M.D.

DISTRICT 8

A general meeting of District No. 8, R.N.A.O. was held in the Nurses' Residence, Civic Hospital, Ottawa, November 4, 130 members being present. The meeting was opened at 9.45 a.m. with Miss Percy, Chairman, presiding. Interesting reports were read on the C.N.A. meeting in Saint John. A Study Committee was formed to make a further study of the Survey Report. The question of unemployment among nurses was discussed and a committee appointed to make an investigation regarding conditions. An address by Dr. L. P. MacHaffie on "The Problem Child of Pre-School Age," followed by an address on "The Problem Child in School", by Miss Florence Dunlop, M.A., of the Public School Staff, proved of great interest and was enjoyed by all present. During the luncheon when the nurses were guests of the Trustees of the Civic Hospital, Dr. B. T. McGhie, Director of Hospital Services for Ontario, spoke on "Opportunities for Nurses in the Field of Mental Nursing." The afternoon meeting was addressed by Dr. Cathcart who chose for his subject "Mental Hygiene and the Nurse."

QUEBEC

HOMEOPATHIC HOSPITAL OF MONTREAL: Miss M. Anderson, 1931, has recovered from her recent operation and has resumed her duties as night supervisor of the Case Room, H.H.M. Following a major operation in June, 1932, Miss A Pearce, 1924, resigned her position as night superintendent, H.H.M., and has accepted an appointment to the Grace Dart Home Hospital in Montreal. Miss T. J. Whitmore, 1925, succeeds Miss Pearce. Miss H. Forbes, 1931, recently underwent an operation for appendicitis and is now convalescing at St. Eugene, Ont. Miss G. Crossfield, 1925, recently underwent an operation and is making satisfactory progress. The staff held a surprise bridge recently in honour of the Misses A. R. Oney and I. A. Hicks at which both brides-to-be were presented with coffee percolators. The Alumnæ Association extends to Miss M. Anderson, 1931, and her family sincere sympathy in the loss of her father. Miss M. Currie has returned from a visit to Amherst, N.S.

C. A. M. N. S.

TORONTO: The annual meeting of the Overseas Nurses' Club of Toronto was held at the Nurses' Residence, Christie Street Hospital, on October 5, with about seventy members present. Everyone was glad to see Miss Hartley who returned to duty on September 1st after a long illness. Report of the various committees were received and plans for the coming year discussed. Miss Wilkinson who had represented the club at the meeting of the All Canada Association held in Saint John at the convention of the C.N.A., gave a report of the session where business of the Association was discussed and officers elected. It was resolved that the Toronto Club request the All Canada Association to place a wreath on the Nurses' Memorial in the Parliament Buildings at Ottawa on Armistice Day. Officers for 1932 and 1933 were elected as follows: President, Mrs. Jack Bell (re-elected); Vice-President, Miss Meiklejohn; Corresponding Secretary, Mrs. McKay (re-elected); Recording Secretary, Mrs. Ross Craig; Treasurer, Mrs. Hanna. Refreshments were served at the close of the meeting and a social half hour provided opportunity for renewing old acquaintances. On a recent Saturday afternoon Miss Edith Campbell (Matron), Miss Meiklejohn, Mrs. Bell and Mrs. McKay motored over to Hamilton to meet Miss Rayside, the newly elected president of the All Canada Association, and discuss various plans of interest for the future.

MONTREAL UNIT

Members of the Montreal Unit, Overseas Nursing Sisters Association of Canada, assembled once again on Remembrance Day at the dinner hour. The annual dinner reunions are becoming more popular as the years roll on, this year's event being the largest group assembled since the nursing sisters returned home. The musical programme was, as usual, ably conducted by the inimitable Jimmy Rice, who this year provided additional pleasure through the golden voiced tenor of radio fame, Jack Vanderstraten. The latter sang many of the well known English, French, Italian and Spanish "gems" and joined in the community singing of the old war-time favourites. The toast to His Majesty, the King, was proposed by the Acting President and Chairman, Miss Claire Gass, and the following lines in memory of those with whom the members meet in spirit only, which were written by one of the members (Winnifred Fray Ramsay), were read by E. Frances Upton.

"WE REMEMBER"

Beloved friends, who gently rest
Beneath God's earth
In far off lands,
Come near, with wings of joy and love.
Sweet comfort bring
To weary souls,
On this Remembrance Day.

We wear your poppies near our hearts,
And the clear vision see
Of your eternal love.
We touch with reverence every petal red.
Memories enshrined
Of our Immortal Dead.
On this Remembrance Day.

And then "The Silence" where our spirits meet,
You are so near,
So very dear,
Again, we tread together, the paths of long ago.
'Twas yesterday.
'Tis now today.
On this Remembrance Day.
The bugle sounds, and to our unfinished tasks
We turn, refreshed.
With power possessed.
Filled by the presence of your calm content,
Of work well done.
Of glory won.
On our Remembrance Day. —W.F.R.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

COLLISON—On June 28, 1932, at Victoria, B.C., to Mr. and Mrs. R. L. Collison (Lorna Colbourne, Jubilee Hospital, Victoria, 1928), a son.

HOPE—On October 8, 1932, at Saskatoon, Sask., to Mr. and Mrs. Earnest Hope (Mabel Cunningham, Guelph General Hospital, 1928), a daughter.

KNIFFEN—Recently in Montreal, to Mr. and Mrs. L. Kniffen, (Jean Burrill, Homæopathic Hospital of Montreal, 1930), a son (Leslie Daniel).

LOVE—On August 16, 1932, at Victoria, B.C., to Mr. and Mrs. J. Love (Hazel Jones, Jubilee Hospital, Victoria, 1927), a daughter.

RETALLICK—Recently, in Montreal, Que., to Mr. and Mrs. M. Retallick (Marie K. Nuise, Homæopathic Hospital of Montreal, 1925), a daughter (Doris Norma).

SAMPLE—On September 26, 1932, at Chatham, Ont., to Mr. and Mrs. Clarence Sample (Margaret Gibson, Public General Hospital, Chatham, 1930), a daughter (Elizabeth Wilson).

WRINCH—On April 30, 1932, at Hazelton, B.C., to Dr. and Mrs. L. B. Wrinch (Frances Johnson, Jubilee Hospital, Victoria, 1929), a daughter.

MARRIAGES

ADAMS—ALBUTT—On August 2, 1932, at Victoria, B.C., Catherine Albutt (Royal Jubilee Hospital, Victoria, 1929), to Jack Adams, of Victoria.

BURKE—McKERRACHER—On October 12, 1932, at Chatham, Ont., Grace McKerracher (Public General Hospital, Chatham, 1924), to Thomas Burke.

CARR—ROBINSON—On September 27, 1932, at Toronto, Ont., Olive M. Robinson (Toronto Western Hospital, 1930), to William Harding Carr.

CAVANAGH—McININCH—On October 27, 1932, at Ottawa, Ont., Bernice McIninch (Ottawa General Hospital, 1929), to Dr. J. V. Cavanagh, formerly of Ottawa, now of Halifax, N.S.

CAVAYE—KERR—On September 9, 1932, at Victoria, B.C., Maeford E. Kerr (Royal Jubilee Hospital, Victoria, 1928), to Douglas Cavaye, of Chilliwack.

CHARTIER—McCARRON—In October, 1932, at Guelph, Ont., Marie McCarron (St. Joseph's Hospital, Guelph, 1929), to Leo Chartier, of Guelph, Ont.

CONNORTON—LAMB—On April 26, 1932, at Victoria, B.C., Frances Lamb (Royal Jubilee Hospital, Victoria, 1929), to Claude Connorton, of Vancouver.

DIES—ONEY—On August 2, 1932, at Montreal, Que., Almeta R. Oney (Homæopathic Hospital of Montreal, 1930), to A. S. Dies. Residing in Montreal.

DWYER—FITZPATRICK—In October, 1932, at Toronto, Ont., Cecilia Fitzpatrick (Hospital for Sick Children, Toronto, 1928,) to Fred Dwyer, of Toronto. Residing in in Chatham, Ont.

FLETCHER—EDE—On September 2, 1932, at Victoria, B.C., Wilburta Ede (Royal Jubilee Hospital, Victoria, 1929), to Walter Fletcher, of Victoria.

GILL—OVANS—On October 12, 1932, at Listowel, Ont., Margaret Merle Ovans (Brantford General Hospital, 1930), to Walter Allen Gill, of West Monkton.

Due to lack of space a number of Marriage Announcements are held over for next issue.
—ED.

DEATHS

BREBNER—On November 9, 1932, at New York, N.Y., Dr. W. B. Brebner, beloved husband of Mildred J. Davidson (Toronto Western Hospital, 1923).

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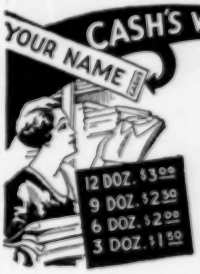

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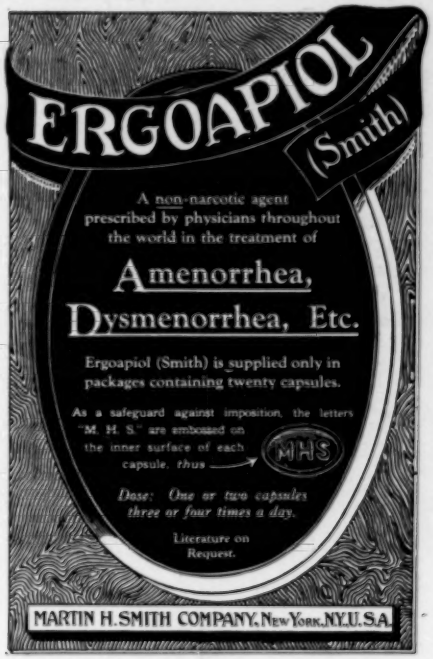
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